## DOCTOR OF HEALTH (DHEALTH)

# The evolving role of the advanced nurse practitioner within UK general practice: A qualitative study on the views of employers, commissioners, GPs, nursing and NHS leaders, and advanced nurses.

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# The evolving role of the Advanced Nurse Practitioner within UK general practice: A qualitative study on the views of employers, commissioners, GPs, nursing and NHS leaders, and advanced nurses.

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It wouldn't have been possible without the nursing participants taking time between their clinics, in their lunch breaks, and at the end of their busy day to take part in this study and talk about their duties, experiences and thoughts on their ANP role. The commissioners, GPs, managers and national leaders were equally obliging and willing to take the time out of their busy diaries to speak with me - thank you to all the participants.

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# Abstract

**Background:** General practice in the UK is facing unprecedented levels of demand following a sustained period of underfunding. Waiting times to see a general practitioner (GP) can be as long as four weeks in some areas of the country. GP numbers are also declining despite an increase in training places and an emphasis on recruitment and retention. Advanced level nurses such as advanced nurse practitioners (ANPs) have operated within general practice for many years and have arguably played a role in increasing access, changing the way patients are managed within surgeries. These nurses have developed their own roles, trained in specialist areas and increasingly taken previously doctor-only duties to meet demand and respond to changes in the workforce. The well-known issues surrounding the lack of ANP regulation, lack of title protection, variability of the role, and differing educational pathways are key factors when considering future strategy for the role and ensuring patient safety. Studies have tended to focus on patient satisfaction levels, outcomes, consultation styles and direct GP/ANP comparisons in the management of patients. This qualitative research study analysed the views of ANPs in the north of England, as well as the views of commissioners, managers, GPs, National Health Service workforce strategists and nursing leaders, on the evolving role of the ANP within general practice. The introduction of the advanced clinical practitioner (ACP) from a range of allied professional backgrounds and its possible impact on the ANP role is also a key line of enquiry.

**Methods:** A qualitative grounded theory methodology in two phases was used to ascertain and analyse the views of a range of ANPs working within general practice. Discussion topics in phase 1 included role development, training, support, how the day to day role has changed over recent years, pressures, financial rewards, perceived threats to the ANP role, and what the future may hold for ANPs. Phase 2 interviews included nursing leaders, commissioners, managers and key stakeholders; comparing and contrasting the views of these participants with those of phase one. The areas for discussion with the managerial, leadership and policymaker participants included workforce analysis, the 2019 GP contract, the Health Education England framework for advanced practice, local and national advanced practice initiatives, and the key stakeholders' views on the ANP and ACP, and how these roles are shaping primary care service provision.

**Analysis:** Grounded theory methodology was used to analyse participants' data. Coding, categorisation, thematic content analysis, theory generation and linking findings with established literature were used to validate the findings.

**Findings:** The data suggested that the ANPs in this study are being used to improve access to general practice and are at the forefront of workforce planning around service provision and dealing with demands. The ANP participants expressed a willingness to retrain, adapt and take on new roles that were previously seen as doctor-only. A reduction in GP numbers and increased demands from patients were key drivers for these changes. The ANPs were also aware that their roles are becoming increasingly medicalised, moving away from a purely nursing model and transitioning to a hybrid role between the nursing and medical domains, blurring the lines between the two professions. There was a contrast in the responses of ANPs and nursing leaders around the future of the role and the nursing background to advanced practice. The introduction of the ACP role, ANP leadership and representation, and the 2019 GP contract were key issues highlighting further differences of opinion between the participants in the two separate phases of the study.

**Contribution to knowledge:** This study highlights the transitional nature of the ANP role towards a possible medical model of practice and a 'third space' between the nursing and medical professions. The introduction of multi-professional ACP training and the standardisation of multi-professional advanced practice may have the potential to improve access and care for general practice patients. Although without strong nursing leadership, recognition that the role is occupying a hybrid domain between the two professions, and a more robust nursing representation, both locally and nationally, there is a risk that the role is misunderstood by national policy makers in their quest to standardise advanced multi-professional practice, whilst not recognising the transition ANPs are experiencing.

# Abbreviations

ACP – Advanced Clinical Practitioner

ANP – Advanced Nurse Practitioner

BMA – British Medical Association

CCG – Clinical Commissioning Group

DOH – Department of Health

GMC – General Medical Council

GP – General Practitioner

HEE – Health Education England

NHS – National Health Service

NMC – Nursing and Midwifery Council

RCN – Royal College of Nursing

QNI – Queens Nursing Institute

# Definitions of Key Terms

### Advanced Nursing Practice

Advanced nursing practice is a level of practice, rather than a specialist area of nursing. Advanced practitioners are educated at a master's level in advanced practice and are assessed as competent to practice using expert knowledge and skills. They have the freedom and authority to act and to make autonomous decisions in the assessment, diagnosis and treatment of patients (Royal College of Nursing [RCN], 2019). The *advanced nurse* may hold various titles and job descriptions, such as ANP or specialist nurse.

### Advanced nurse practitioner (ANP)

An ANP is a registered nurse who has acquired the expert knowledge, complex decision-making skills and clinical competencies necessary for an expanded scope of practice, the characteristics of which are shaped by the context and/or jurisdiction in which they are credentialed to practice. A master's degree or master's level study is recommended for entry level (International Council of Nurses [ICN], 2019). ANPs are found throughout all clinical areas of the UK healthcare system.

### Advanced Clinical Practitioner (ACP)

Advanced clinical practice is a level of practice to which healthcare professionals can aspire. ACPs are from a range of professional backgrounds, such as nursing, pharmacy, paramedics, occupational therapy, healthcare science and midwifery. ACPs are educated to at least a master's level and have developed the skills and knowledge to allow them to take on an expanded role and scope of practice (NHS Employers, 2019). Consequently, the designation of ACP is being increasingly used to describe any professional that has been educated to undertake an advanced role, including nurses, pharmacists, physiotherapists and paramedics.

**General Practitioner (GP)**

A GP is a physician without a formal specialisation but has a medical practice (general practice) in which they treat and manage patients with a broad range of illnesses (*Collins Dictionary,* 2019). In the UK, following their general medical training, a doctor wishing to train to become a GP is required to undertake a period of rotation through various specialities, including gynaecology, surgery, medicine, paediatrics, A&E or psychiatry, after which they will undertake 18 months of GP registrar training, followed by an exam.

**General Practice**

General practice is the work of a GP (a doctor) who treats those residing with a designated catchment area, and with presenting problems that do not require hospital treatment (*Cambridge English Dictionary,* 2019). A GP surgery in the UK can encompass numerous healthcare professionals working as a team, including a GP, practice nurse, ANP, healthcare assistant, pharmacist, physiotherapist and others.

**Health Education England (HEE)**

The HEE is a national leadership organisation for education, training and workforce development in the healthcare sector. The HEE is an executive, non-departmental public body sponsored by the Department of Health and Social Care.

**Royal College of Nursing (RCN)**

The RCN is a trade union that has been in existence since 1916. It supports nurses and promotes the vital importance of nurses in healthcare. The RCN began as the College of Nursing, a professional organisation with just 34 members. Since then, the RCN evolved into the largest professional association and union for nurses in the world with more than 435,000 members.

**Nursing and Midwifery Council (NMC)**

As the professional regulator of nurses and midwives in the UK and nursing associates in England, the NMC works to ensure that these professionals have the necessary knowledge and skills to deliver consistent, quality care so as to ensure patient safety.

**British Medical Association (BMA)**

The BMA is the trade union and professional body for doctors and medical students in the UK responsible for employment advice, career development and professional regulation. The BMA leads the debate on ethical, scientific and public health matters through research and publications. They are the UK's independent regulator of doctors, helping to protect patients and develop medical education and practice

# Chapter 1

# Introduction

## 1.1 Introduction

This study focuses on the role of the Advanced Nurse Practitioner (ANP) within UK general practice. It aims to explore how this role continues to evolve in response to both increased patient demand and a reduction in the number of General Practitioners (GPs) (Maier et al., 2017). The aim is also to make policy recommendations based on the findings. Its objectives are to develop insights into the perceptions of ANPs themselves regarding their role, pressures, changing status and possible future innovations, and to compare these ANP perceptions against the views of managers, GPs, commissioners, the National Health Service (NHS) nursing leaders and other key stakeholders.

Increasing economic and healthcare demands, alongside needs to cut expenditure and provide localised, efficient and high-quality, *on-demand* healthcare (NHS England, 2014), in conjunction with a declining GP workforce, have resulted in a need to adapt the working practices of doctors, nurses and allied professionals. Non-medical professions are expanding their scope of practice into previously doctor-only areas, blurring the lines of the professions where there was once a clear demarcation of domains (McInnes et al., 2015). When a nurse undertakes specialist training to carry out a role previously undertaken by a doctor, such as prescribing or managing a patient's condition from start to finish without any other medical intervention, they are said to be working at an *advanced* level (RCN, 2012). A multitude of titles, roles and duties have emerged. New models of community healthcare delivery increasingly offer ANP-led services as opposed to GP-led services. Advanced practice roles are no longer limited to nurses, with paramedics, physiotherapists and pharmacists undertaking advanced practitioner training and being used in primary care to fill gaps in the provision of services and to provide patients with an alternative to a GP (Kooienga and Carryer, 2015). Although advanced practitioner roles are now filled by a multitude of professionals with a range of clinical backgrounds, by far the most commonly encountered and best established of these is the ANP (Health Education England [HEE], 2016).

Across the globe, the nursing profession has been at the forefront of responding to demographic changes, with nursing practices evolving to meet the demands of an ageing population, increasingly complex comorbidities and chronic disease, as well as

financial austerity (Freund et al., 2015). A shortage of doctors, especially in low-income countries, has resulted in nurses being utilised in increasingly medicalised roles (Donelan et al., 2013). These changes are also apparent in many high-income countries experiencing their own doctor shortages, especially in socioeconomically deprived and rural areas (Nardi and Diallo, 2014). Although ANPs have made their presence felt across all clinical domains, their role in general practice has advanced the role of all nurses, not just ANPs, with this progression of the nursing role in general practice happening faster than in other areas of nursing (Freund et al., 2015).

Nevertheless, legislation, governance, regulation and title protection for ANPs in the UK has been slow and sometimes non-existent with respect to determining what tasks an ANP can perform, their boundaries and title protection (Kooienga and Carryer, 2015). This has led to considerable variability in ANP practice and confusion amongst employers, GPs, commissioners and ANPs themselves. Despite the lack of title protection and variability in the role, ANPs have excelled in primary care with multiple studies demonstrating equal or better outcomes for patients from ANPs when compared with GPs in areas such as prescribing, patient satisfaction and cost effectiveness (Scum et al., 2000; Horrocks et al., 2002; Sakr et al., 2003; Nadaf, 2018; Casey et al., 2018).

ANPs in UK general practice are now undertaking many advanced activities that were previously undertaken by GPs, for example chronic disease management (lung disease, diabetes, asthma), managing triage and home visits, carrying out minor surgical procedures, being responsible for contraceptive devices, acute clinics, sole responsibility for end-of-life care, becoming partners in the business, and undertaking senior leadership roles (Nadaf, 2018). This evolution of the advanced nurse in general practice shows no signs of slowing. As other advanced roles begin to emerge within a range of professions, it is appropriate to ask whether ANPs themselves accept and are willing participants in these changes, or whether they feel pressured to adapt and assume these new roles. The UK GP contract is a five-year agreement between NHS England and GP representatives. The framework within the contract is periodically renewed, setting out the provisions for funding, services, vision and direction for general practice for the next several years. The 2019 GP contract outlined a central role for advanced practitioners from pharmacy, paramedic and physiotherapy backgrounds to improve access to GP surgeries (without directly promoting nursing) (NHS England, 2019). At the time of writing, many of these posts remain vacant and there are ongoing questions regarding the funding for these roles and their longevity (Pearce, 2019). This study focuses on the established ANP role as there are no studies exploring ANP views with respect to these changes and the ongoing development of other advanced practice

roles. It is also important to consider the views of those who employ ANPs, as well as commissioners, workforce strategists and NHS leaders with respect to the role. Their understanding of the scope of the role, its background, limitations and possibilities is a new area of study. The ways in which their views are consistent, or not, with ANPs will be of particular interest, that is, it is important to understand how these stakeholders perceive the role of advanced practice, what they regard as the priorities for the workforce and how ANPs' may or may not conform with stakeholders' perspectives.

This research uses a grounded theory approach, as described by Charmaz (2012), to undertake semi-structured interviews with two groups of participants in two phases. ANPs in the north of England were interviewed and their responses analysed before the second group of interviews with GPs, commissioners from various clinical commissioning groups (CCGs), primary care workforce strategists, NHS leaders and key nursing representatives was undertaken. The following section outlines the aims and objectives of this research.

## Aim

The overall aim of this research is to explore, compare and contrast the views of ANPs, managers, NHS leaders, commissioners and employers with respect to the current and evolving role of the ANP in primary care general practice regarding training, support, role development, governance and issues relevant to the ANP workforce. This study aims to develop insights into how the ANP role is currently practised, assess perceptions about ANP practice held by a range of stakeholders, develop a new understanding of the role, determine if the current systems of developing and supporting ANPs are fit for purpose, and make policy recommendations based on the findings.

## Objectives

- To determine the views of key stakeholders, commissioners, managers, GPs and nursing leaders with respect to the ANP role in primary care, future innovations and potential for cost savings and efficiencies.

- To explore the current working practices of ANPs in general practice, their drivers, barriers, influencing factors, limitations and boundaries.

- To determine how the ANP workforce views the evolving role of the ANP in general practice and what further developments they believe are required to meet patient demand.

- To understand not only the pressures upon ANPs and the nature of their evolving role but how these changes impact ANPs themselves on a personal, professional and group level.

- To explore the perspectives of NHS leaders, commissioners, managers and GPs with respect to the ANP role and to analyse the data for similarities and disparities.

- To determine whether there are any disparities between the views of commissioners and ANPs themselves around the role, its competencies, and potential innovations and cost efficiencies, and what implications these may have for workforce planning, training and role development.

- To make recommendations with respect to the future role of the ANP within general practice regarding training, support, development, cost savings, efficiencies and governance.

## 1.2 Personal Motivations

Working as an ANP for the past 10 years, I have seen many versions of what it means to be an ANP with varying levels of advanced practice, titles, duties and qualifications. I have worked in accident and emergency (A&E) departments, community nursing, rapid response, rehabilitation and general practice. I have witnessed and undertaken advanced practice roles within each of these areas, seeing nurses becoming increasingly specialised and technical, and have observed the language of nursing change with the increased integration of medical terminology and practices. I have witnessed an increased focus on aspects of care that have historically been considered the domain of medicine, for example, discussions around test results, diagnostic investigations, pharmacology, service targets, documentation, procedures and clinical pathways. Nursing education also transitioned to graduate status and lost its bursary, contributing to nursing becoming a more scientific, educated profession.

Throughout my career, I became increasingly aware that nurses were very eager to develop their roles and to integrate into their nursing work practices and tasks understood historically to be the domain of medicine. Following this trend, I decided to

undertake the advanced practice master's degree in 2009 over 3 years, then worked as an ANP following its completion. I began working in general practice in 2010 and continued to be interested in advanced nursing and its development, which led to me undertaking an MSc in healthcare leadership in 2015 with the NHS Leadership Academy. I continued to see nurses assuming roles that were previously considered part of the medical domain. These creeping changes included triage, minor surgeries, endoscopies, acute home visits, running services (anticoagulation, women's health), becoming partners in general practices alongside doctors, nursing home *ward rounds*, end-of-life care, prescribing specialist drugs, being the point of contact for specialisms and being the lead practitioner in certain services, such as walk-in centres and minor illness clinics.

During the years spent in primary care and general practice, ANPs were describing their role evolving into a more medical type role and a replacement for GPs due to recruitment problems. In casual conversations and observations, I began to witness ANPs taking on acute home visits, triage, out-of-hour services, minor surgeries, specialist clinics, a bigger role in prescribing, dealing with complex multi-factor consultations and taking a leadership role within the practice. Overall, ANPs seemed to enjoy these changes, whilst GPs and commissioners appeared content in allowing the role of the ANP to progress. Over the past 9 years, I have witnessed not only the role of nurses changing considerably but also the roles of healthcare assistants, pharmacists and GPs evolving. Healthcare assistants now do a large majority of what practice nurses did 10 years ago, whilst practice nurses are increasingly dealing with a range of minor illnesses; what the first ANPs did over 10 years ago,

These developments might be explained by such factors as the shortage of doctors, a lack of funds as well as mounting pressure to promote efficiency or even the general advancement of the nursing profession. However, one question that has always interested me is what motivates a nurse to want to take on a more advanced role and to undertake duties that were previously in the medical domain? Are such nurses motivated by financial reward, status, improving the care of patients or is it something else? Also, how does the nurse feel when they carry out this role? Are they more stressed, content, sufficiently trained, do they feel pressured into carrying out a new role? I was also interested in how the ANP is viewed by their managers, directors and employers. Are they seen as a cheap option? Are they considered reliable? Are the outcomes the same? Are services being designed around the role?

These queries were in the back of my mind for many years, and when the opportunity came along to undertake a doctorate, I developed my interest further by developing this research study. This topic is very timely with a significant reduction in GP numbers, increasing patient demand and the advent of several advanced clinical roles, including paramedics, pharmacists and physiotherapists. The study has attracted interest from the Royal College of Nursing, the Queens Nursing Institute (QNI), CCGs and HEE, with applications for funding being successful with the QNI and HEE. This study is unique in comparing the views of ANPs with those of managers, commissioners, NHS leaders and GPs. By making this comparison, I have found that the growth of the ANP at a local level has been organic, facilitated by both patient demand and workforce changes, and has happened in ways that regional and national level organisations seem not to grasp.

## 1.3 Structure of the thesis

This thesis is structured in the following way:

**Chapter One:** This chapter provides the abstract, background and introduction to the research. Definitions of key terms are also provided.

**Chapter Two:** A critical review of the literature is provided, including NHS demand, advanced practice, the history behind the ANP role, efforts to regulate the ANP, the nurse–doctor relationship and leadership.

**Chapter Three:** This chapter explains and justifies the methodological approach used in this study and describes the choice of research methods. The epistemological approach, methods of data analysis, ethical considerations and trustworthiness of the data are discussed.

**Chapter Four:** This chapter presents the research findings. These findings are divided between those pertaining to the ANP interviews (Phase 1), and those based on interviews with managers, commissioners, GPs and nursing leadership (Phase 2).

**Chapter Five:** A discussion on the findings and relevant theories relating to the data and how these relate to the literature. The limitations of the study are also discussed.

**Chapter Six:** Conclusions and recommendations are presented, as well as the strengths and limitations of the research, opportunities for further research and an estimation of the overall contribution of this study to the body of knowledge surrounding the ANP role.

# Chapter 2

# Literature Review

## 2.1 Introduction

The purpose of literature reviews in grounded theory studies has long been disputed by theorists (Charmaz, 2014; Tummers and Karsten, 2012; Glaser and Strauss, 1967). One of the most hotly debated and contentious issues in grounded theory concerns whether the literature review should be carried out before or after the data has been collected and analysed (Charmaz, 2014). Glaser (1998) argues that the review should be carried out after the data has been analysed in order to avoid contaminating or influencing any emerging concepts. Corbin and Strauss (2008) take a contrasting view, suggesting that the literature be used to enhance the data collection phase of the research by shaping the initial questioning of participants and giving the researcher an understanding of the topic. Reviewing the literature before data collection can also help to identify any knowledge gaps, facilitate the process of ethical approval and help to focus the direction of the research (Tumers and Karsten, 2012).

In this case, the review of the existing knowledge and literature was carried out prior to data collection for pragmatic reasons. This review was performed to analyse the existing literature around the ANP role, to demonstrate a sound knowledge of the subject area, to determine any possible gaps in the research, and because it is a requirement of academic student progression and necessary to obtain ethical approval. These factors are recognised by Charmaz (2014) as a requirement of doctoral students when undertaking grounded theory studies. A literature review was necessary to approach the research with up-to-date knowledge, an understanding of the current issues around advanced practise and to ensure the fieldwork addressed a gap in the knowledge and was relevant.

Because grounded theory studies do not have a set research question, hypotheses or a central theory to be proven, the format of the literature review differs somewhat as compared with other methodological approaches. In fact, it is not unusual for grounded theory research to dispense with a dedicated literature review altogether, preferring instead to reflect upon the literature throughout the thesis. Other grounded theory studies, however, might incorporate and reflect upon the literature throughout the various chapters, as well as in a more substantial section or chapter towards the end of the thesis. Nevertheless, others might follow a more traditional approach, with the

literature review appearing early in the thesis and reflections upon this literature appearing throughout the course of writing (Dunne, 2011).

The style and method of the grounded theory literature review also differs as compared with other presentations of research. The review of the literature should not influence the researcher's approach to data collection or predispose the research to any bias in terms of theories or preconceptions (Glaser, 1991). The review should not highlight a research question, nor should it focus the examination of knowledge gaps to a single area because the concepts and theories should emerge from the data rather than any pre-defined gap in the literature (Hallberg, 2010).

In this study, the review of the literature provided a background and basis for undertaking the research, fulfilled the requirements of the academic process and provided validity for the methods used, being carried out before, during and following data collection, and throughout the duration of the doctoral education. This is consistent with the suggestion of Charmaz (2012) that grounded theory should embrace a dynamic approach in dealing with the literature, engaging with the literature as an ongoing practice throughout the entirety of the research process 'without letting it stifle creativity'. The review in this study provides a thorough background to the research and knowledge in key areas and findings of the research, rather than following a formulaic structure of a literature review which would include a search strategy and inclusion and exclusion criteria (Hussein et al., 2017).

This chapter will critically review the literature relevant to the ANP role, focusing on general practice, pressures on the NHS and primary care, the introduction of the 2019 GP contract and how these factors have influenced workforce changes within GP surgeries. The evolution of the ANP role from its inception to the present day status of ANPs as autonomous practitioners is presented, along with a discussion of the factors influencing the development of the role, how the role has adapted to cope with changing demands and how nurses have come to perform an increasing number of previously doctor-only tasks. Relevant legislation, health policy and emerging national strategies for the regulation the ANP role are explored, along with current policies and guidelines concerning what constitute advanced practice.

## 2.2 Increasing Demands on the NHS and Primary Care

In October 2017, the then Secretary of State for Health, Jeremy Hunt, acknowledged that the NHS was facing 'heavy pressures'; demand had grown beyond expectations and poor planning over many years, especially around the needs of the workforce, had contributed to these pressures (BMJ, 2017). The 2017/2018 winter period was viewed by many as one of the worst on record for the NHS (NHS Improvement, 2018). This period saw the NHS treat more patients than in any previous winters. Approximately 5.87 million people visited A&E departments in January to March 2018 (220,000 more than usual); 1.1 million people were admitted (70,000 more than usual); GPs reported seeing significantly more patients, with a subsequent increase in GP appointment waiting times; and key national performance targets slipped, with the A&E 4 hour target slipping from 89% to 84% as compared with the previous year (NHS Improvement, 2018). The problems faced by the NHS over this period were not an isolated cause of concern, with the demands on the healthcare system having been increasing over several years (NHS England, 2018). Missing A&E targets are now an all-year-round occurrence, and as shown in Figure 1, these benchmarks are worsening each year.

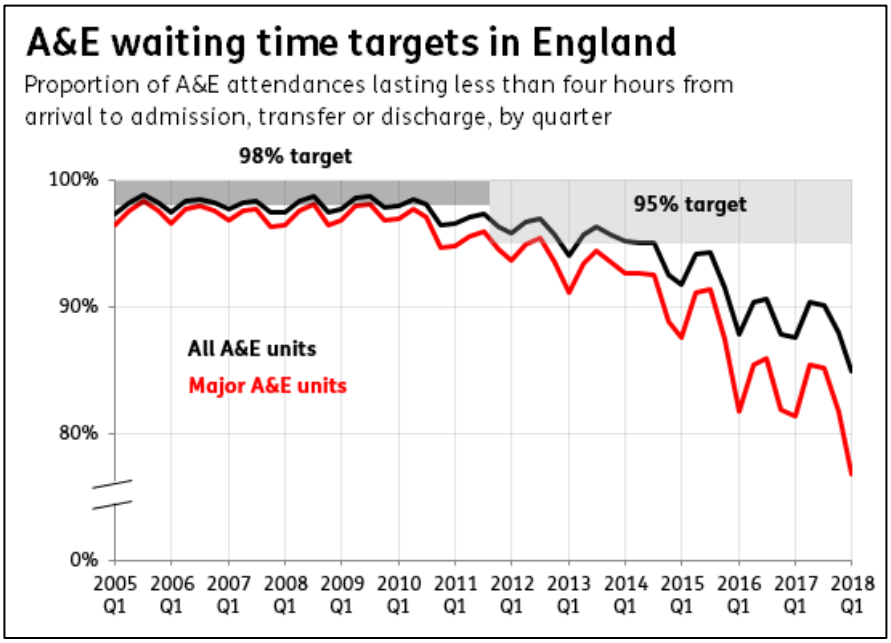


Figure 1: NHS England (2018) – A&E Attendances and Emergency Admissions 2017–2018.

As of 2019, there are over 4.2 million people on NHS waiting lists for consultant-led treatments, the highest figure on record according to the latest Kings Fund quarterly report (2019). The performance report also shows that the 4-hour A&E wait time target continues to be missed, whilst the number of emergency admissions rises each quarter

of each year. Turning to NHS finances, the target of a £391 million budget deficit for the previous financial year was missed by a considerable margin, with NHS providers returning a £591 deficit in 2018/2019 (NHS Improvement, 2019).

From 2010 to 2015, the NHS has arguably gone through one of its most challenging and financially restricting periods in its history. This is demonstrated in Figure 2, which shows a plateau in the overall spending on health from 2010 to 2016 (Economics Help, 2019).

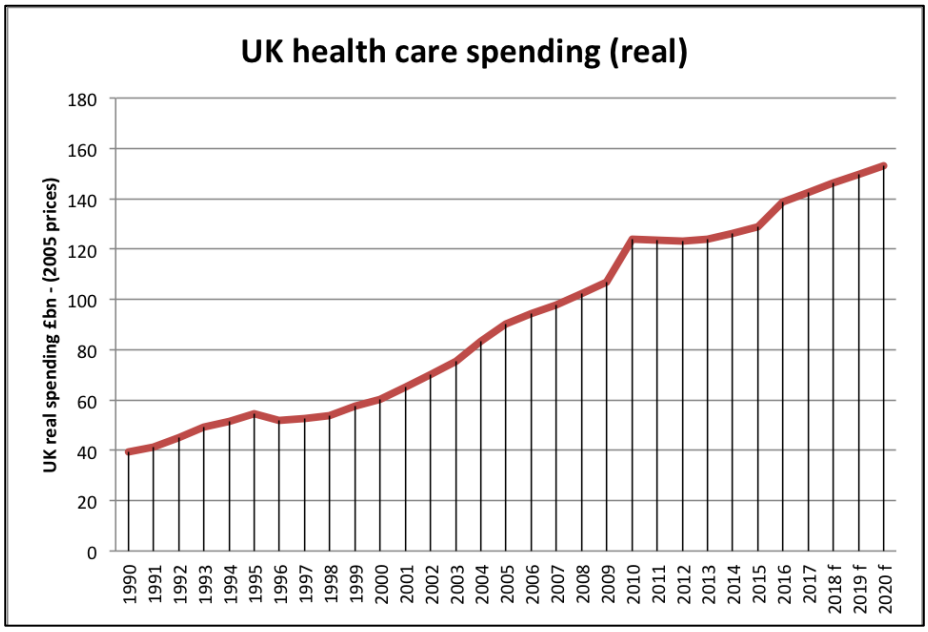


Figure 2: UK healthcare spending in real terms (Economics Help 2019).

A Kings Fund (2016) report published after several years of the NHS budget having been frozen shows that healthcare spending on the NHS has not risen in line with gross domestic product (GDP). This report also shows that the previous 5 years, which essentially amounted to a freeze on funding, plus an overall 8 years of austerity, led to debt, deficit and a 'hole that would take multiple years to fill' (Kings Fund, 2016).

The corresponding issues associated with a levelling off of funding (reduced investment and innovation, lack of recruitment, cost cutting) have been particularly felt within primary care, in which the rising demand for services has been met with declining budgets and a drop in the number of staff. It has been purported that if general practice fails, the whole NHS fails (Roland and Everington, 2016); with even a 1% drop in GP appointment numbers nationally potentially resulting in a 10% increase in A&E attendance figures (NHS Improvement, 2017). A report by the BMA in late 2018 showed that GP surgery investments and funding had reduced significantly from 2005 to 2015,

as shown in Figure 3. Although the investment and funding of GP surgeries has increased in recent years, surgeries face a similar situation to that of hospitals wherein the extra funding may not repair the damage already done (BMA, 2018).

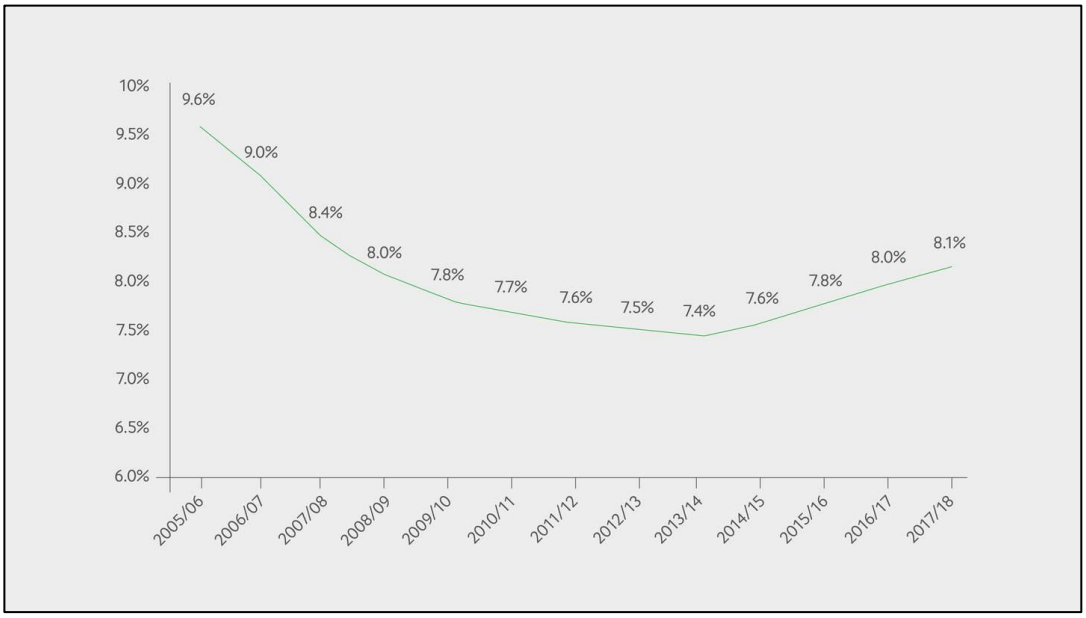


Figure 3: General practice funding as a percentage of total NHS funding (BMA 2018).

## 2.3 General Practice

Before the foundation of the NHS, GPs worked as purely private entities, treating patients only if they were paid. The 1911 National Insurance Act, introduced by Chancellor Lloyd George, and the 1948 creation of the NHS changed the landscape and working practices of GPs (Kmietowicz, 2006). GPs were no longer ethically troubled by their patients' inability to pay, although this led to an initial overwhelming of general practice which the NHS did little to resolve (Loundon et al., 1998). In 1952, an amalgamation of poor working conditions, unkempt and dirty consultation rooms, a lack of funding and an unclear direction led to GPs forming the College of General Practitioners (Kmietowicz, 2006). This was done in an attempt to develop general practice as a clear career path, to establish an academic body of GPs and to create an entity to push for reforms. The government of 1976 passed legislation requiring all doctors wishing to become GPs to undergo supplementary training, establishing general practice as a clear career path and profession equal to other areas of medicine (Kings Fund, 2011).

The 1980s and 1990s showed increased scrutiny on general practice, with a need to demonstrate quality and effectiveness, but also increased autonomy, with the GP fund-holder initiative allowing GPs to commission services on behalf of their patients and take a more incentivised involvement in the wider health system. The mid-1980s also saw the introduction of computers into general practice, which led to the digitisation of patient records. The 1970s and 1980s also saw the evolution of the Advanced Nurse in the United States, especially in hospitals (Barton, 2006); at the same time, the UK saw the introduction of the First Contact Practitioner and an increasing number of advanced nursing roles, perhaps in response to the need to promote greater efficiency and improved outcomes (NHSME, 1991). The late 1990s, under a Conservative government, saw the introduction of locally negotiated contracts enabling GPs to work more flexibly. This was expanded further under the 2003 Labour government, allowing GPs to work as locums, salaried GPs or as partners. The 2000s saw the launch of the NHS plan, which brought greater scrutiny and the introduction of incentivised targets, the performance management of GPs and the abolishment of the responsibility of GPs to provide overnight care to patients (Kmietowicz, 2006). This period also saw the scrapping of the general practice boundaries (a defined catchment area for each surgery from which the surgery could take patients), the introduction of patient choices and competition between practices to *poach* patients and to obtain contracts for various services.

The shape of service provision also underwent significant change with the introduction of advanced roles for general practice nurses, such as chronic disease management, contraception and prescribing, a change that had already taken place within hospitals. Defined training for nurses to undertake more medicalised roles began to be rolled out in universities for general practice nurses. From 2005 onwards, the GP workforce was recognised as being under significant pressure, with many GPs approaching retirement age, experiencing increased demand from patients and a burgeoning administrative burden (Appelby and Robertson, 2016). The 2008 global financial crisis saw an end to increasing funding and recruitment and an emphasis on austerity, efficiency savings and cost reductions. The period between 2010 and 2016 saw NHS funding largely frozen, which in practical terms was aimed at reducing spending (Economics Help, 2019; Roland and Everington, 2016).

The NHS England (2016) action plan to recruit an additional 5,000 GPs by the year 2020 is nowhere near this target, and with an actual reduction in GP numbers, it would seem that this goal is likely unachievable. In light of financial pressures, a lack of recruitment, few opportunities for training and retention problems, the workforce and

general practice as a whole is reaching crisis point (Doran et al., 2016). Figure 4 displays the number of GPs in the UK per 100,000 head of population. This figure shows a plateau between 2008 and 2014, followed by a significant reduction in GP numbers between 2014 and 2018, equal to a drop from 67 to 60 GPs per 100,000 (NHS Digital, 2019).

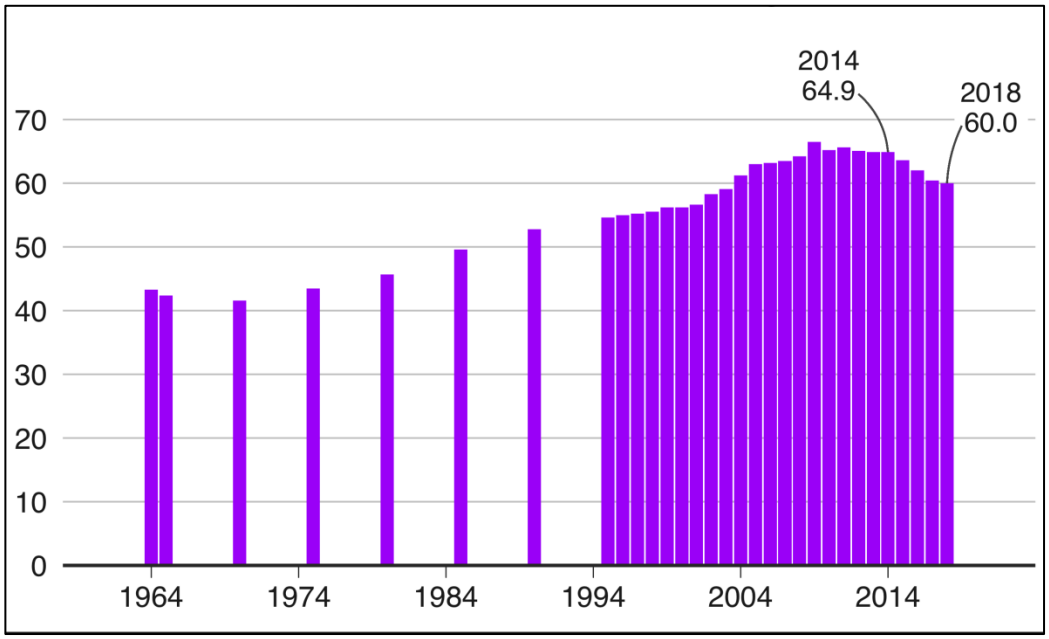


Figure 4: Total number of GPs per 100,000 head of population in the UK (Nuffield Trust 2016).

Despite the drop in GP numbers, the number of nurses and other direct patient care staff working in general practice has continued to rise. The overall number of nurses grew by 1.5%, or 240 full-time equivalent (FTE) staff, taking the numbers to 16,040 between September 2017 and September 2018 (Health Foundation, 2019). Interestingly, much of this growth was due to an increase in the number of ANPs and extended role practice nurses, although this needs to be considered against a backdrop of 41,000 nursing vacancies within the NHS as a whole (Health Foundation, 2019). This figure may be misleading, however, as many of these roles are filled by agency staff, overtime hours and temporary staff, and therefore have not been left vacant (FullFact, 2019). These figures also do not include general practice nursing roles. The annual number of working nurses within the UK over the 2010–2016 period rose from 501,000 to 675,000 before falling to 639,000 in 2016–2019 (UK Statista, 2019). Interestingly, the RCN has linked this reduction to the withdrawal of the nurse education bursary in 2017 (RCN, 2018). The well-documented problems with GP numbers and recruitment have led to a variety of roles being introduced to general practice. The past 5 years have seen nurses assuming more technical and advanced roles within surgeries (Wickware,

2019). Nevertheless, while workforce strategists and commissioners have been slow to recognise these changes, they have presumably been sanctioned by the nurses' managers and employers (Laurant et al., 2018). Patients appear comfortable attending appointments with nurses for previously doctor-only tasks (Nadaf, 2018), and it appears that this transition from a GP-first model to a multi-profession general practice shows no signs of abating.

It is increasingly viewed that a major shift is needed away from the doctor-centric healthcare model, to one that is truly a shared-care model, in which increasingly varied types of clinical support (nurse practitioners, pharmacists, physiotherapists and others) work in collaboration with GPs (Thompson and Walter, 2016). The workload, a reduction in the number of GPs, patient demand and an evolving, increasingly "advanced" workforce is driving this shift. The BMA describe the necessity of the changes:

> In a large organisation such as the NHS where there is a near constant process of service redesign, it is inevitable that new roles will be created from time-to-time. While it is true that new clinical roles spring up from new approaches to service delivery, they may also arise from new ideas on career progression or out of necessity, for example when there is a shortage of doctors and the introduction of the advanced clinical practitioner. Currently, with NHS funding stretched, a medical recruitment and retention crisis and the ongoing agenda of moving care into the community, we are seeing an unprecedented period of new clinical role development.
>
> – BMA, (2019)

A retrospective analysis by Hobbs et al. (2016) showed that general practice was top heavy, with three times more GPs than general nurse consultations. However, this analysis was for the 2007–2014 period, with more recent data showing a rise in nurse consultations (NHS Digital, 2018). This is relevant when considering advanced nurses taking over aspects of the GP role, with studies of the type of consultations with GPs showing that many presenting conditions could be managed by pharmacists, nurses or other relevant practitioners (Wickware, 2019). Within the area where this present research was undertaken, it is clear that GP consultation numbers have declined and that ANP consultation numbers have increased over recent years, as indicated in Figure 5.

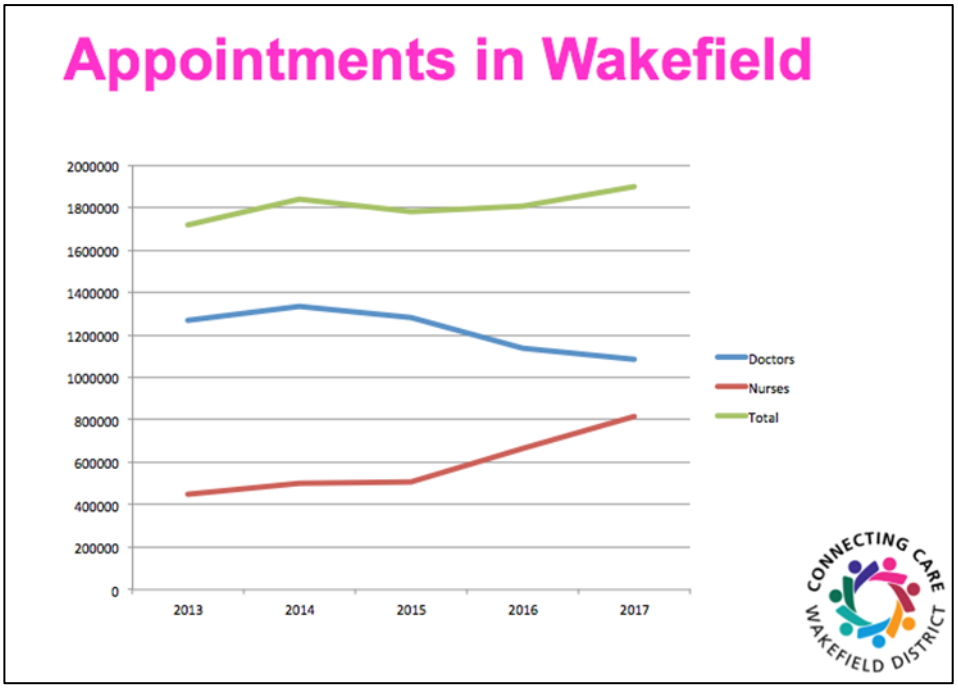


Figure 5: Appointment types, Wakefield 2013–2017
(Wakefield workforce development academy 2017).

There is broad agreement amongst stakeholders that: (a) the share of NHS funding directed to general practice in England has declined in recent years from 11% in 2005 to 7.2% in 2016 (RGCP, 2015), (b) the workload has increased substantially (LGA and NHS Confederation, 2015), and (c) patient satisfaction with access to GP services has declined in recent years from 80% being satisfied in 2009 to 69% in 2015 (Appelby and Robertson, 2016).

The increase in workload and demand for GP consultations is difficult to quantify and to explain. There is a lack of data as to the reasons for this increased demand for healthcare in general and specifically for GP appointments. Consequently, neither the government, nor NHS England, nor local commissioners demonstrate a robust understanding of the level of demand for services (National Audit Office, 2015). Individual consultation data has only recently become available after years of the Department of Health and NHS England having not collected any information on the increasing numbers (Kings Fund, 2016). The overall workload of GPs in England rose by 16% in the 7 years up to 2014, with more frequent and longer consultations (Hobbs et al, 2016). Nonetheless, this is overshadowed by a separate 93.6% increase in the rate of telephone consultations with GPs and nurses. During the same period, there was a 1% decline in FTE GPs, with 54% of older GPs (above 50yrs) reporting a considerable or high likelihood of quitting within 5 years and 82% intending to leave or reduce their hours (Dale et al., 2015). In 2018 alone (March–June), the FTE number of

GPs fell by over 500, whilst the number of nurses in general practice increased by 108 (NHS Digital, 2018).

The Primary Care Workforce Commission (2015) report also states that planning within primary care is difficult because of the lack of reliable data regarding the number of disciplines within primary care, their professions, level of training and future needs. Research into the *understanding of demand* would have fundamental implications for the future of workforce configuration, with the Workforce Commission (2015) stating that 'we don't just want to know how many people are accessing or would like access to a GP appointment, we need to know why and what drives them to request to be seen'. There is a need to know what the patient wanted or needed, and who would be best to help, which may not always be a GP, but maybe a nurse, pharmacist or another professional (Box, 2016). Accessing a GP surgery appointment is a growing problem within UK primary care, with a focus on GP numbers and waiting times, but a lack of clarity on the impact of this problem on other professionals working within the general practice environment.

Problems with GP surgery accessibility have been shown to have a direct *knock-on* effect with other areas of the NHS. For example, timely access to a GP surgery (not necessarily a GP) could alleviate visits to A&E, particularly during peak out-of-hours times (4–7 pm) (Cecil et al, 2016). The number of A&E visits annually rose by 20% between 2008 and 2012 (HSCIC, 2013). Up to 40% of these visits are believed to be inappropriate (Martin et al, 2002); many of them could be treated within primary care by GPs, nurses and pharmacists., Some patients seen in A&E departments have attributed their visits to their inability to obtain a GP appointment (Agarwal et al., 2012). Access to a GP surgery appointment within 2 days is associated with a reduction in A&E attendance (Cowling et al. 2013).

Difficulty in accessing a GP is also felt in out-of-hours healthcare provision. An observational study by Morgan and Beerstecher (2011) involving 13 primary care trusts and their extended-hours services showed an increase in the demand for Saturday appointments, but no corresponding increase for any other period. GP surgeries that offered services and appointments outside of usual hours usually had higher levels of patient satisfaction and a reduction in out-of-hours visits to other service providers. The study also found that patient satisfaction was not linked to any particular increase in appointments for a specific time or day. Trends in national patient satisfaction surveys were not linked with any particular extended hours opening times, rather an increase in general access to GP services, and not necessarily a GP (Op Cit., 2011)

With the increased pressure on general practice, dwindling GP numbers, resources being cut, and rising costs, it is becoming increasingly commonplace for ANPs to substitute for GPs in various roles. A study in the Netherlands of 12,000 patient consultations with GPs and ANPs by Beizen et al. (2016) showed that there was no difference in clinical outcomes between teams comprising solely GPs and mixed GP/ANP teams. A direct comparison showed that ANP care resulted in less resource usage and improved cost savings when compared with GP care, with each consultation costing less for an ANP than a GP. Although these findings might not necessarily be generalisable to the UK context, it does reflect other findings from studies based in the UK. A Cochrane review by Laurant et al. (2018) of nurses as substitutes for doctors in UK primary care showed that for some ongoing and urgent physical complaints and for chronic conditions, trained nurses (e.g. nurse practitioners, practice nurses and registered nurses) provide equal or possibly even better quality of care as compared to primary care doctors, in some cases achieving equal or better patient health outcomes.

The role of the ANP has developed significantly over the past decade and is now a common addition to the GP surgery workforce. This rise in numbers and changes to the role within primary care is probably a direct result of the increased demand from patients and recruitment issues with GPs, as well as bridging the gap in the hours of junior doctors within hospitals. Barton et al. (2012) recommended several years ago, that the ANP role be further developed in response to this increased demand and reduction in the number of GPs, with further adaptation made to ensure an appropriate response to the increased restrictions on healthcare resources and demographic changes. These recommendations were difficult to follow up on at the time due to the projected 50,000 shortfall in nurses by 2016 (Lintern, 2012), a number, as noted above, that continues to hover around 41,000. If, as appears to be the case, these advanced roles are expanding within general practice and undertaking previously doctor-only tasks in an effort to meet patient demand and fill the gaps due to reduced GP numbers, analysis of the history of the nurse–doctor relationship may help to elucidate how the blurring of professional lines might impact this partnership.

## 2.4 The Nurse/Doctor Relationship and Professionalisation

It is important to consider the concept of professionalisation when analysing the current and future role of the advanced level nurse, comparing this concept with other professions, especially medicine. If an ANP is to continue to assume roles traditionally

considered the domain of the GP, their professional status and how they are viewed by the wider workforce and general public may become important determinants of their success. Wiltz (1990) states that the professionalisation of a role often creates a hierarchical divide between the knowledge authorities in the professions and a deferential citizenry. This results in *occupational closure*, in which the role becomes separate and closed off from amateurs, the layperson and outsiders (Macdonald, 2004). The professionalisation of medicine emerged in the mid-1800s out of self-regulation, the British Medical Act of 1858 and the founding of the British Medical Council. Moreover, early doctors saw themselves as learned gentlemen (the role was almost exclusively male), above the general public, and possessing a specialised body of knowledge that set them apart (Waddington, 1990). The role became increasingly specialised, separate from amateurs and protected by legislation. Nursing has taken a similar path, although its struggle for recognition as a profession, which has involved shaking off the *doctor's handmaiden* image, has been difficult (Rodrigo, 2014). The introduction of degree level nurse education, shared responsibility for patients, advanced nursing roles taking over previously doctor-only tasks and professional registration has reduced the hierarchy gap between the professions, although the social status and salary of a doctor or surgeon still outweighs that of a nurse (Bradshaw, 2018).

McGregor-Robertson (1902) wrote that the nurse must begin her work with the idea firmly implanted in her mind that she is little more than an instrument for carrying out the doctor's instructions; she occupies no independent position in the treatment of the sick person. This statement demonstrates how far the nursing profession has advanced in a century, for as Radcliffe (2000) suggests, patients arguably decide the relationship with and status of nurses themselves; the public loves its caring angels but holds its medics in awe. Nevertheless, the status and nature of this relationship may be changing in response to the increasing levels of publicity being afforded to medical and nursing fallibility, with stories of medication errors and medical blunders causing these professions to lose some of their magical aura and gloss (Stein et al., 1990). This also has implications for the ANP in general practice if they are to take over previously doctor-only roles, leaving themselves open to increased scrutiny and to the risk of complaints in the process. Whilst the public's perceptions of what a nurse can and cannot do is evolving, public opinion is far from settled on exactly where the nurse fits into the medical care of the patient—whether they are a central figure managing the patient from beginning to end or whether they are simply an addition to the medical profession (Bradshaw, 2018). As nurses become increasingly *advanced* in their roles, titles and perceptions become more important. Nurses' views of their own place in the

team are important, as are the views of their managers, employers, commissioners and NHS leaders, all of which have a significant impact on the scope of the role and its future. The literature, however, is not clear on the issue of how the perceptions and beliefs of ANPs influence their practice. There is also a distinct lack of policy with which to guide advanced nursing (Schober, 2013). Such ambiguities may affect the public's views of ANPs and where their role fits into the general practice setting.

A large study by the Health Professions Council (2011) was undertaken to increase the understanding of professionalism, what this term is perceived to indicate and how a lack of professionalism can be recognised. It indicated that professionalism has a basis in individual characteristics and, more importantly, the organisational support, workplace, expectations of colleagues and leaders, and individual patient encounters. The regulation of a role provides only basic signposting as to what is considered appropriate professional behaviour, with the workplace, collegial expectations and organisational ethos having a more significant influence on professional attitudes (Health Professions Council, 2011). These findings are relevant for the present study because they would suggest that the professionalism of ANPs might be influenced by the changing attitudes of commissioners, managers and leaders. If the direction of travel for the ANP role, from the point of view of NHS leaders, is for a more advanced technical/medical role, the identity, professionalism and attitudes of ANPs might be subject to influence by this change.

The growing body of literature on professional identity and its influence on the effectiveness of ANPs indicates that effectiveness is reduced when the ANP questions their role, title and boundaries (McNeil et al., 2013; Aranda and Jones, 2008). It is not known if managers, commissioners and NHS leaders also question the identity and role of the ANP and where it fits into the provision of services. It has been suggested that perhaps it would be more appropriate to dispense with the *advanced nurse practitioner* title, preferring instead *advanced practitioner*, thus aiding the public's understanding of the role (Leary, 2017). Such titular changes for advanced practice might be the inevitable result of the 2019 GP contract, which collectively describes advanced practice nurses, physiotherapists, pharmacists and paramedics as ACPs (Advanced Clinical Practitioners). It is debatable whether nurses and other allied health professions are content with being grouped together under the ACP title, or whether they wish to remain distinct separate professions. If the boundaries are blurring between not only GPs and nurses, but within the professions working as ACPs, one might reasonably question whether the public will be aware of who is consulting with them and the nature

of their professional background. It is also debatable as to whether existing ANPs will embrace the ACP title.

Ongoing changes to nurse education, along with the introduction of master's level advanced nursing roles, has widened the gap between qualified nurses and untrained healthcare workers or carers. This can be confusing for the public or patients who may fail to recognise the disparity (Leary, 2017). The advent of highly educated nurses taking on more medical roles could result in basic *nursing* care being deferred to unqualified or *non-professional* staff (Snell, 1998). Since the early 1990s, the trend has been to move nurse training to higher education with degree status training, which has resulted in nurses assuming a more technically orientated role (Bradshaw, 2018). This left enrolled nurses (i.e. non-degree nurses) at the time having to assume a more *hands-on* role in patient care, freeing up the registered nurse to focus on their technical roles. Health care assistants (HCA) were also susceptible to *role drift* at this time and took on more clinical and technical tasks, such as blood tests, diagnostic procedures (e.g. spirometry and ECG recording) and minor wound dressings (McKenna, 2004). The HCA in a modern GP surgery is capable of undertaking blood pressures, wound care, blood tests, spirometry, ECG recording, certain injections (e.g. B12 and shingles vaccinations), and running flu vaccination clinics, all whilst being unlicensed, unregulated and unsupervised.

The enrolled nurse has now ceased to be a recognised nursing role/title, whilst the recent introduction of the *associate* nurse appears to fulfil the same functions in all but name (Smikle 2016), with the graduate nurse appearing to be pushed, once again, into a higher technical, managerial and leadership role (Glasper, 2016). With the graduate nurse becoming more *advanced*, the actual advanced nurse has inevitably become more technical and medicalised, further blurring the lines between the nursing and medical professions (Shirie, 2013). The Wanless (2005) review by the RCN showed that advanced nurses could assume approximately 20–40% of the work currently being performed by physicians in all aspects of healthcare; moreover, the introduction of the European Working Time Directive meant that doctors were no longer available all of the time, thus leaving a gap into which nurses would have to assume some aspects of the doctors' role (Fagin and Garelick, 2004). These events further added to the image of nursing as a serious profession.

The division of labour is an economic concept which supposes that dividing the production process into different stages enables workers to be better focused on specific tasks; if workers can concentrate on one small aspect of production, this

increases overall efficiency—so long as a sufficient quantity is being produced (Pettinger, 2013). This is relevant to healthcare as the NHS, as well as nursing care, is divided into sub-groups and specialists; for example, HCAs and associate nurses undertaking a more *hands-on* approach to care, whilst degree and master's degree nurses take on a more *medicalised* role. The division in this example may be more influenced by the need to cut costs rather than a true division of labour, with nurses taking on medical and unqualified nurses taking on previously qualified nurses' roles to reduce overall staffing costs. The nursing profession is now highly specialised into not only adult and child nursing, but community, oncology, rehabilitation, end-of-life, and emergency nursing, amongst many others; consequently, the general *staff nurse* is now virtually a thing of the past (Shield and Watson, 2007). This specialism and the move away from the *general nurse* are what are commonly thought to have paved the way for the ANP role, along with a shortage of doctors (Shirie, 2013). Although productivity may increase with sub-groups of workers and specialists, the opposite may also be true with smaller organisations not seeing the benefit and *generalists* not being available. The role of the ANP in general practice is a generalist role; nevertheless, it may become more specialised as time passes. The concept of the ANP/ACP housebound/home visit or triage specialist may not be too far away. The student nurse is also graduating with a degree and more advanced skills, which may also result in less qualified personnel taking on new roles and this may in turn contribute to further expertise and status drift.

The nurses' role is becoming ever more skilled, with the boundary between the roles of doctors and nurses becoming increasingly blurred. Within the UK, advanced nursing roles have had an unregulated and ill-defined journey over many decades, thus making it worthwhile to analyse this journey and what the coming decade might hold for advanced nurses.

## 2.5 Advanced Practice

Nurses have been advancing their practice over many decades from the original *doctors' handmaiden* role to the highly trained independent specialist nurses of today. The New Deal (NHSME, 1991) was a key policy document in the formation of the advanced nurse's role. The New Deal introduced new working arrangements for doctors and set explicit limits on the number of contracted hours for junior doctors. It also introduced the *sharing* of clinical tasks and roles by nurses and midwives, promoting the

development of various initiatives in the UK, blurring the boundary between nursing and medical roles and duties (Allen, 2001).

The term *advanced practice* and its definition has troubled workforce strategists and researchers for many years (HEE, 2019). Advanced nursing practice in the UK began in the 1970s and grew noticeably in the 1980s. Since its inception and the introduction of clinical nurse specialists, few attempts have been undertaken to provide a clear definition for the concept of advanced practice (Hill, 2017). Despite (or because of) the multiple reasons for the development of advanced nurses—including a shortage of medical staff following a reduction in the clinical time of doctors, changing healthcare needs of the population, continuity and quality of care, and the desire of nurses for career progression (Sheer and Wong, 2008), no attempt has been made to standardise advanced nurses, with the skills and scope of practice remaining unclear. In theory, and without appropriate legislative protections, anyone can call themselves an *Advanced Nurse* (Nadaf, 2018). A survey by East et al. (2014) found a considerable variation in the education, levels of practice, titles and role requirements of hospital advanced nurses. Despite the lack of clarity around the role, health policy and service design continue to regard advanced nursing as an established solution to the increased demand for health care and the need for efficiency and cost saving (Hill, 2017).

The RCN launched a pilot scheme in 2016 which involved putting approximately 30 advanced level nurses through a *credentialing* process. Under this scheme, a competency checklist is used by assessors to *credential* advanced practices against the RCN's four pillars of advanced practice: clinical, education, leadership and research. A complete roll-out of the scheme commenced in the summer of 2017 and has been met with a mixed reception due to several factors (Campbell, 2018). Firstly, the assessment process costs the nurse approximately £350 every 3 years and is non-refundable should the participant not succeed. Secondly, the credentialing process is for *advanced practice* and not for any role or title, and thirdly, it is completely voluntary and is thus not required to qualify, gain employment or to practice as an advanced level nurse. The NMC have no official or statutory involvement in the RCN's credentialing process; as such, it is unclear to what level the NMC and other bodies might buy into this process, how it will impact the profession, and to what effect the credentialing of ANPs will impact the role. Due to the NMC's lack of involvement and current reluctance to regulate the role, it is difficult to see what impact the RCN system will have and what the future will bring for the ANP with a voluntary, costly and unproven system of credentialing. The recent introduction of allied health professionals as advanced

practitioners may follow a similar evolutionary path as did nursing. With this in mind, it is worth examining how the title and role of the ANP originated and how it has evolved.

## 2.6 The Advanced Nurse Practitioner

The role of nurse practitioner was first introduced in the United States in the 1960s in response to the need for innovation and healthcare reform (Barton, 2006). Following this, the UK, Canada, Taiwan and Australia introduced similar advanced practice models (MacLellan et al., 2015). Since this time, there has been a worldwide demand for nurses with enhanced skills who can manage a more diverse, complex and acutely ill patient population; consequently, a variety of advanced practice nursing roles have evolved around the world (Duffield et al., 2009). These roles have evolved on an ad-hoc basis depending on the level of need and patient population. Today, the *advanced nurse* has as many titles as there are roles, resulting in a confusing overlap of roles (Sheer and Wong, 2008). Descriptions of the ANP vary from one country to the next, with some regulating the title, whilst others only define advanced practice in general terms. It is estimated that at least 70 countries either have or are considering introducing advanced nursing practice positions (ICN NP Network, 2012). Nevertheless, the ANP is generally accepted to be a nurse who has studied at a high level, acquired skills comparable to that of a junior doctor and is capable of working autonomously. Questions remain, however, as to whether the role is still based in nursing or whether ANPs are working with a model that places them more within the medical domain as opposed to nursing (Casteldine, 2003). As such, the line between advanced nursing practice and the medical profession has been blurred.

Although the NMC in the UK has not defined the ANP, the NMC defines advanced practice as being performed by highly experienced and educated members of the team with the ability to diagnose, treat and refer to an appropriate specialist if needed (NMC, 2005). Rolfe (2014) criticises this definition, arguing that the NMC definition is vague and might be equally applied to any healthcare professional, including doctors, and does not apply purely to nurses. The RCN (2012) published a set of guidelines for the ANP role, these guidelines aimed at defining the concept of advanced practice and establishing competencies necessary for the awarding of the ANP title. This list of competencies includes diagnosing, prescribing, leadership, screening, ordering investigations and interpreting results. These competencies are broad recommendations (which appear to apply to any advanced healthcare provider, not only

nurses) and are not mandatory. These statements and documents appear to have contributed little towards the formal recognition of the ANP role, nor have they resolved any issues pertaining to disparities in the role, the inappropriate use of the title or the variability seen in ANP practices (Stasa et al., 2014).

The only regulatory or statutory requirement for advanced nursing practice in the UK is the requirement to record prescribing qualifications with the NMC. Despite lobbying from various nursing and professional bodies, a 2009 report on professional regulation in the UK concluded that advanced practice can be embraced within the scope of initial nurse qualifying registration without the need for additional regulation (CHRE, 2009). As such, it would appear that it is possible within the UK for a registered nurse who practices completely within the scope of the code of conduct to carry the title of ANP if their practice is at a sufficiently advanced level due to their advanced knowledge and experience, despite them having not completed a designated education programme or being entered into any ANP register, should one exist (Stasa et al., 2014). In the UK, the titles of ANP, advanced practitioner and specialist practitioner are not protected and might be used to describe any nurse who practices with a high degree of autonomy and responsibility across education, management, research and clinical care (RCN, 2012). As such, it is up to local managers and employers to decide upon the title, as well as the role and responsibility of the advanced practitioner, if they are satisfied that the individual is working at a sufficiently advanced level. The CQC (2016) states that the ANP title is not recordable on the nurse register; therefore, in theory, ‘any nurse can call themselves an ANP’. In mid-2019, the NMC announced that it would undertake a review in consultation with key stakeholders to determine whether new regulations and a registration process were needed for ANPs. Despite the NMC having made a very similar announcement 10 years prior (Mitchell, 2019), there is growing recognition that a national strategy is needed to reduce the confusion and variability in the advanced practice role.

## 2.7 Role Confusion, Variability and the Lack of Regulation

The titles of specialist nurse, nurse practitioner, ANP, advanced practice nurse, clinical nurse specialist and nurse consultant may arguably be interchangeable (Wilson-Barnett et al., 2000). However, Duffield et al. (2009) highlight that there is a distinct difference between ANPs and specialist nurses, with specialist nurses focusing on a specific, well-

defined area of nursing, whereas ANPs operate at an autonomous level in many practice settings, managing a wide variety of patients and conditions.

The UK's position on ANPs is confusing and unregulated (Maylor, 2005; Buchan and Calman, 2004; Castledine, 1997). In 2004, the NMC launched a consultation exercise on the framework for post-registration nursing. This process, however, was deeply flawed and was not representative of the workforce, with a low response rate, lobbying from key stakeholders and multiple responses from single individuals (Ball, 2005). Nevertheless, the NMC accepted the findings and announced that those operating at an advanced level of practise should be registered and regulated, with the then government producing a white paper advocating that common standards, systems and practices should be developed and regulated (Department of Health, 2007). Three years later, the Prime Minister's Commission (2010) called for the regulation and registration of advanced practitioners in England based on their achieving of established competencies. However, following a change in government, these proposals were deemed unnecessary, with 'no compelling case being made for further regulation'. The NMC has rejected the standardisation of advanced nursing roles, titles and certification, moves that they view as overly restrictive on the scope of nurses and the ability of the profession to adapt to changing healthcare needs (Nadaf, 2018; Jowett et al., 2001), although they have recently expressed a willingness to re-examine this stance. This is in contrast to the RCN credentialing scheme which rejects any nurse working at an advanced level if they do not meet their specific criteria. In mid-2019, the NMC agreed to hold a review of the nurses register around advanced practice and to liaise with key stakeholders around the need for a possible extended register of ANPs. Few details are available, however, with which to describe either how this review will be formatted or its duration.

A report by the RCN in 2005 cataloguing the practices and roles of nurses did little to propose any standardisation of the different advanced roles despite calls to do just that (Lankshear et al., 2005). Internationally, the ANP role and the concept of advanced practice lack clarity, with considerable variations in the regulation and execution of roles from one country to the next (Stasa et al., 2013). A lack of role definition, clarity and guidance with respect to responsibility is problematic for ANPs who may be unclear as to their precise responsibilities and limitations. Other healthcare professionals might be similarly unclear on the scope of practice of ANPs, as might educational providers and also patients who may not know when they should be consulting with an ANP as opposed to a GP (Stasa et al., 2013).

One might also argue that this lack of regulation and a permissive approach to the advanced nursing role is precisely what is needed to promote innovation and development, thus making the role more adaptable (McGee, 2009). Despite the publication of a formal position statement by the Department of Health (2010), ambiguities remain within the UK around the concept of advanced nursing practice (Kleinpell et al., 2014). These ambiguities stand in stark contrast to the regulation of the medical profession and the roles of doctors within the UK. At the time that the number of ANPs had begun to proliferate, there was no systematic understanding of what was considered advanced nursing practice, nor was it clear what kind of work ANPs were doing in practice, how they should be remunerated, nor what their development/training needs might be (Hill, 2017). As for staff nurses aspiring to become ANPs, despite the lack of any clearly defined career pathway, there was a bewildering array of courses available (Donald et al., 2010). This confusion and the lack of a clear pathway to advanced practice has been somewhat clarified in many countries, although the UK still lags behind in many areas. In many countries, an ANP is required to have completed a master's degree before registration (Redshaw and Harvey, 2001). The UK has no such educational requirements nor any central register for ANPs. Researchers and authors, such as Rolfe (2014) and Barton et al. (2012), observe that the NMC does not formally recognise the ANP, but does recognise advanced practice, although there is no mention of the quality or level at which the advanced practice is to be performed beyond a basic assumption of competence.

Bostock (2008a, 2008b) found that 18% of nurses using the ANP title (or *nurse practitioner*, as used in these studies) were found to lack the qualifications they claimed to have. Moreover, Snow (2008), Bostock and Lepper (2007), and Castledine (2005) reported that nurses were on a slow transition towards ever-increasing levels of advanced practice beyond their initial scope, moving into the advanced practice domain without necessarily having undergone a commensurate level of training or holding corresponding qualifications. Once on this slow transition, the lines between normal high-level nursing and advanced practice can become blurred, leading to nurses, as noted above, sometimes calling themselves ANPs without having the necessary formal training or qualifications (Nadaf, 2018; Snow, 2008).

The level of complexity associated with nurses who expand their roles into advanced practice is further exacerbated by the fact that there are few controls over the use of titles or the proliferation of roles. There are also seemingly few restrictions on the type of tasks and practices undertaken by ANPs, with some undertaking endoscopies, managing myocardial infarctions in A&E departments, conducting minor surgeries,

undertaking acute home visits and even running GP surgeries as ANP partners without any GPs. What few controls and guidelines that exist have been limited in their impact. As the role has expanded unchecked, the NMC's unwillingness to recognise and to regulate the role has brought into question their ability to govern ANPs and advanced practice (CHRE, 2012). The role, being ill-defined, is open to potential abuse, although lack of definition could aid or hinder innovation and the development of the role. On top of that, there is a distinct lack of research in this area, although studies have shown ANP care and outcomes to be on par with or superior to that of doctors (Sakr et al., 2003; Horrocks et al., 2002, Scum et al., 2000). Despite the ambiguity and confusion around the role, it is argued that the ANP is a move towards a more medical model of nursing, or a hybrid of the two professions (Woo et al. 2017). Nevertheless, the causal factors behind this innovative move to a possible medical model remain unclear. It is plausible that any attempts to regulate or define the actual work of the ANP (such as in the case of the RCN credentialing process) may have a negative effect on ANP outcomes by restricting innovation, development and their ability to adapt. The NMC does not see regulation as a priority, nor does it see advanced practice as posing a heightened risk to public safety (Santry, 2010).

Although ill-defined and unregulated, the ANP role has become widespread within the NHS and has established itself as a legitimate level of nursing, having been effective in meeting the increased demands on healthcare over the 2010–2015 periods (Nadaf, 2018). A qualitative focus group study by Jones et al. (2015) found than ANPs, managers, commissioners and education providers felt strongly about the capacity of the ANP role now and into the future to meet consumer demand and to fill gaps in the system of healthcare provision. While the study noted the ill-defined nature of the ANP role, the findings demonstrated that ANPs fulfilled an essential function in the current market of healthcare provision.

As previously discussed, the advanced practitioner role can now be found in allied professions—pharmacists, physiotherapists and paramedics—although these advanced allied professionals number far fewer than advanced nurses. Recognising that advanced practice was becoming a multi-profession concept, the HEE undertook a competency framework strategy in 2016 in order to ensure that all professions were working at the same level.

## 2.8 The multi-professional framework

It became necessary to attempt to address the confusion and lack of definitions around advanced practice in 2016/17 when allied professions (e.g. paramedics, physiotherapists and pharmacists) were highlighted as key to the redesign of health services, being touted as the 'new advanced practitioners' alongside nurses (HEE, 2017). If a multitude of professions were going to work alongside nurses as advanced practitioners, a national strategy would be required to ensure that everyone would be working at the same level. The advanced practice competency framework, launched in 2017, aimed to define advanced practice and outlines a set of competencies for professionals, regardless of their background profession, if they are to be considered advanced practitioners (HEE, 2017). This competency framework provides current and future ANPs/ACPs with guidance and principles to follow throughout their professional lives, outlining a clear career pathway into and through the profession. The framework promises to draw upon and consolidate existing frameworks of advanced clinical practice from across the UK (HEE, 2017). There is uncertainty as to the mandatory nature of the criteria and who exactly it is aimed at—existing and experienced professionals, newly qualified professionals or staff wanting to become advanced level practitioners. The framework describes all professionals working at an advanced level as *ACPs* but refrains from mentioning any professions by name or identifying the particular skills of a nurse, paramedic, pharmacist or physiotherapist.

The four pillars of advanced practice are described by the RCN (2018) as key requirements of any nurse working at an advanced level. These four pillars are advanced clinical practice, management/leadership, research and education. A nurse working at an advanced level should demonstrate that they fulfil the criteria in each one of these *pillars*, although there are no statutory or regulatory bodies in the UK or England authorised to adjudicate on this. The HEE (2017) competency framework builds upon these four pillars to examine the individual's daily role, education background, level of autonomy and responsibilities for decision making. The HEE competency framework is not the first such strategy for dealing with advanced practice. A similar framework was first introduced in Scotland in 2008 and included a toolkit aimed at providing guidelines on how to introduce, support and promote advanced practice roles (Scotland 2008).

HEE use the expression *master's level award* within the framework, which may confuse some clinicians and employers, and might possibly lead to discrepancies with

remuneration (Nadaf, 2018). The previously held view of the RCN, that all ANPs should have completed a full master's degree, does not appear to be shared by HEE:

> Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.
>
> – HEE, (2019)

The 2017/2018 period saw many new developments around advanced practice following the introduction of the RCN credentialing scheme, the HEE (2017) framework and the introduction of degree apprenticeships for advanced practitioner courses (NHS Employers, 2018). These developments meant that NHS affiliated organisations could access sources of funding to further develop their workforce, a move aimed at promoting the development of advanced practitioners.

The 2019 GP contract also articulated a central role for the ACP in the redesign of general practice. The contract recognises the need for a diverse general practice workforce and offered funding for a network of practices to share the employment of ACPs. Nevertheless, there has been criticism of this contract as it appears to promote other advanced professions before nursing (Paddison, 2019), despite the fact that nurses have an already well-established role within the general practice setting.

## 2.9 The ACP/ANP Comparison and the 2019 GP Contract

The *General Practice Forward View* (2016) highlighted the need for a more diverse workforce within general practice and a move away from the doctor-centric model. This policy document and contract was devised by NHS England and sets out a vision of general practice that includes many professions and specialists for the management of patient care. The document envisages paramedics as undertaking home visits, pharmacists conducting medication reviews and physiotherapists assessing chronic and acute joint conditions. Although this was broadly met with approval by the RGCP (Mathers, 2016), some medical groups expressed concern in the years leading up to the publication of the document regarding the introduction of non-medical roles, expressing their concerns through remarks, such as 'Dr Nurse will see you now' or 'The rise of the noctor', *noctor* being a derogatory word meaning 'not a doctor' (Nabi, 2015; Coombes, 2008). The *General Practice Forward View* (2016) was followed by the *Framework for Advanced Practice* (HEE, 2017) which established a set of criteria not

only for nurses but for all professions to meet in order to work at an advanced level. Following this, a steady stream of physiotherapists, pharmacists and paramedics began to undertake advanced clinical practice master's degree courses from 2016 onwards alongside nurses (BMA, 2019). They were all referred to as ACPs. In light of the 2019 Kings Fund report, which demonstrated that general practice has 2500 fewer FTE GPs than it needs (Kingsfund, 2019), the 2019 GP contract talked extensively about the need for ACPs, even offering to fund 70% of their salary for the next 5 years (NHS England, 2019). These new roles were specifically listed as 'paramedics, pharmacists, physician associates and physiotherapists'. Physician associates are a very new role within the NHS, with no prescribing rights and no governing body. All these roles working at an advanced level were grouped together under the ACP title. However, the contract made no mentioned of advanced nurses, ANPs or specialist nurses within general practice, although it makes note that the practise nurse workforce was experiencing similar shortfalls as GPs.

University advanced practice education courses have now adopted the ACP title (previously nurse practitioner courses) as their qualification and renamed their courses as *advanced clinical practitioner* master's degrees, open to various professions. But the problem of defining the role and actual practice requirements remains. The title of ACP is still relatively new and may cause some confusion amongst employers and existing ANPs regarding their levels of training, titles, the equivalence of roles/professions and salaries (Nadaf, 2018). As with ANPs, the confusion and plethora of advanced practice titles naturally leads to variability in the roles they undertake. Despite the role confusion, lack of clarity, variability and unregistered nature of the ANP/ACP, studies have shown no discernible difference in the care afforded to patients by ANPs as compared with medical doctors in terms of clinical outcomes or patient satisfaction levels (Sakr et al, 2003; Horrocks et al., 2002; Scum et al., 2000). These findings have been borne out in a more recent study by Oliver (2017), showing that patient satisfaction levels and clinical outcomes are equal to, if not better than, when care is provided by a GP.

## 2.10 Nursing Leadership

National nursing leadership within the UK is derived from numerous sources, including the RCN, NMC and lead nurses within NHS England. Local leadership within organisations and CCGs can also have an impact on how advanced nurses carry out their roles. The role of the ANP can vary from one GP surgery to the next due to

differences in the model of care and role articulation, leadership within the organisation or a lack of support networks. The four pillars of advanced practise include leadership/management as a key aspect of advanced practice, with ANPs being senior, experienced and highly educated nurses, able to lead and manage others. National nursing leadership and the promotion of advanced nurses as an integral and important part of the team is a more debated area. A recent 2017 conference on advanced practice demonstrated common disagreements with respect to advanced practice and the lack of a unified voice within nursing (Nadaf, 2018). National nursing leadership opinions have varied from 'nursing is still subservient to medicine' and 'ANPs are still seen by employers as a stop-gap measure in a crisis' to 'the boundary between nurses and doctors becoming increasingly blurred because of the changed balance of knowledge and power amongst nurses and doctors, resulting in nurses being more able to lead clinical practice alongside doctors than ever before' (LSBU Health Debate, 2017). There has been a clear shift, over many years, away from the nurse being the 'doctor's handmaiden' and of them needing to 'know their place' (McGregor-Robertson, 1902). Speakers and leaders also acknowledge the lack of strategic workforce planning for advanced practice and the *ad-hoc* way in which roles have developed, lacking cohesiveness and a brand or identity, which may be due to a mixed national leadership strategy or lack of direction.

Perhaps this lack of any overarching strategy for advanced nursing practice, the lack of regulation and the lack of title protection can be viewed as a symptom of wider problems within nursing. Nursing arguably became a profession rather than a *calling* or a task-orientated role when it became a university graduate level occupation. The Griffiths Report (1983) introduced a system of management with a single general manager responsible for all operations. This new structure removed nurses from senior management roles and thus was poorly received by nurses. It required nurses to be accountable to non-nurses for the first time in decades, removing them from the decision-making process and raised questions around nursing's professional status and position in society (Owens and Glennerster, 1990). This policy has obviously since been reversed, but it nonetheless demonstrates the perception that nurses are subordinate to the managerial and medical members of the team. The 1989 white paper, *Working for Patients* (Roberts, 1989), saw the introduction of an internal market within the NHS. The white paper also emphasised a need for competitiveness, which was at odds with the values of partnership, teamwork and collaboration to which nurses had been accustomed and further set nursing aside from the decision-making table (Baggott, 1994). The white paper also positioned doctors as managers, rather than having

doctors as subordinate to managers, but did not involve nurses as decision makers. This situation has changed over recent decades, with nurses now acting as managers, coordinators and directors, although the public and media still fail to recognise the scientific, educational and professional aspects of nursing (Ten Hoeve, 2013), with the media still depicting nurses as working at the patient's bedside and performing repetitive and routine tasks, and thus still stereotyped somewhat as the doctor's handmaiden (Sawbridge, 2015).

It has been argued that a strong unified nursing voice is needed to shape the profession and plan for the future healthcare needs of the population (Bodell, 2019). This voice has tended to become lost in the overall discussion around healthcare policy and service design, often being overshadowed by the medical profession (Cummings et al, 2017). This is evident in the 2019 GP contract, which appears to emphasise and provide funding for advanced practice roles other than nursing, which has already proven its effectiveness. In Sweden, medicine and nursing are equal partners, and Australian nurses are educated to similar levels as doctors; seen at first by the medical profession as a threat, Australian doctors now acknowledge nurses as their equal (Shields and Watson, 2007). If the lines between advanced nurses, ACPs and doctors become further blurred, nursing will require a strong voice and leadership to demonstrate its ability to flourish in this role whilst protecting its nursing roots (Bodell, 2019). Nevertheless, nursing leadership has thus far struggled to define advanced practice or to ensure that it remains a fundamentally *nursing* role (Stasa et al., 2013). With the introduction and development of advanced practice roles for allied health professionals, there is a risk that existing role boundaries may become even further blurred and turn into role conflicts, referred to as *turf wars* (DiCenso et al., 2010). The direction of travel is one of advanced practitioners of various backgrounds undertaking general practice consultations, an area of practice currently occupied almost solely by nurses. The effect on nurses and GPs of a new advanced role evolving alongside them is unclear and requires that nursing leadership act with unity and strength (Bodell, 2019).

## 2.11 Summary

This literature review and background to the study has discussed the pressures on UK general practice and the NHS, the evolving nature of the nurse–doctor relationship and its evolution into a modern joint-working partnership, how this has led to a blurring of the lines between the professions with the introduction of the ANP and advanced practice

also having been analysed. The literature indicates much confusion around the role and shows that attempts to define the ANP and protect its scope and boundaries appear to have failed. The growth of the ACP may further complicate the already misunderstood area of advanced nurses, especially amongst the medical profession. The 2016 *General Practice Forward View* document and the 2019 GP contract set out the intended changes to general practice, outlining how advanced practitioners will 'fill the gaps' in service provision and enable patients to receive care from a variety of professions, not only GPs. The ANP role continues to evolve and may be going through a process of transitioning into a multi-professional ACP role, or possibly defining its own path and direction. The notion of a hybrid nurse/medical role is also a possibility. Despite the ANP having been a feature of general practice for many years, the notable absence of the ANP from the 2019 GP contract in favour of pharmacists and paramedics is worthy of note

## 2.12 Gap in the knowledge

There is a body of research that has explored ANPs in the hospital setting. Issues of role ambiguity and variability are evident in studies by Gardner et al. (2007), Tye and Ross, (2000), Woods, (1999), and Rolfe and Phillips (1997). These studies have highlighted the turbulent process by which the advanced role has developed, as well as the lack of vision and strategy inherent in its deployment. Each of these studies relied upon qualitative methodologies, including the use of action research, grounded theory and case studies. More recent studies concerning the ANP role and its implementation, such as the study by McDonnell et al. (2014), have also tended to draw upon qualitative methods to evaluate the implementation of the ANP role within the care setting. Early research on the ANP role tended to focus on how the role had been implemented and evaluated (Martin and Hutchinson, 1999), whilst more recent studies have focused on outcomes, drawing comparisons with doctors, especially around issues of cost savings, patient satisfaction and performance indicators (Ryskina et al., 2019; Swan et al., 2015).

Martin and Hutchinson (1997) highlighted common ANPs feelings of being undermined by doctors, a lack of recognition and their frequent use as a *stop-gap* measure. Another study, this time by Williamson et al. (2012), explored the role of ward-based ANPs in an acute medical setting, finding that advanced nurses acted as lynchpins, enhancing communication and practice, pioneering the role, being a role model and facilitating the

patient's journey, but again found variability and role confusion. Dalton (2013) used a grounded theory approach to explore perceptions of the ANP role and found issues of role vagueness and ambiguities with the various definitions of advanced practice. Issues with communication and the educational needs of ANPs emerged, as did issues of role boundaries.

There is a paucity of literature and research regarding ANPs within *general practice*, and as such, it may be useful to either replicate some of the aforementioned studies, tailoring the research to suit the style of work inherent to GP surgeries. Tye and Ross (2000) studied the issue of role overlap and role boundaries between advanced nurses and doctors within a UK acute emergency setting using semi-structured interviews, case studies and documentation. Their study highlighted concerns with nurses encroaching upon medical territory, junior doctors missing out on experiences with minor illnesses and training being prioritised for nurses over that of junior doctors. To date, no comparable study has been conducted within UK general practice.

There are significant gaps in the literature with respect to the perspectives of ANPs on the ongoing changes to general practice, how their roles have adapted to meet growing patient demand, and how a reduction in GP numbers might be continuing to impact their scope of practice, the type of consultations they undertake and the blurring of professional boundaries. The personal experiences, thoughts, feelings, pressures and worries of the ANP workforce regarding their current role within general practice and their ability to cope, adapt and evolve further is worthy of further research. Such research, however, is conspicuously absent from the literature. There is a clear gap in the literature with respect to the thoughts and real world experiences of highly trained ANPs on the introduction of the new ACP multi-professional role, how advanced nursing may have to compete with advanced allied professionals and how ANPs see advanced nursing evolving in the coming years. The blurring of professional boundaries between doctors and nurses, with nurses assuming responsibility for an ever-increasing number of previously doctor-only tasks also needs to be studied from the GP, managerial and commissioner perspectives, with this representing another clear gap in the literature. Assuming that GPs, managers and commissioners are fully aware of the transition taking place, what processes and policies have been put in place to aid or mitigate this evolution and to inform the public? How do GPs and commissioners feel and react to these changes? Are the views of employers, commissioners and managers consistent with those of ANPs? There is a paucity of research aimed at resolving these questions, demonstrating a gap in the literature comparing the real-world experiences of ANPs in general practice with the official national strategy and direction.

# Chapter 3

# Methods, Methodology and Data Analysis

## 3.1 Introduction

This chapter will outline this study's epistemological approach, research design and methodology. It used an adapted form of qualitative grounded theory, in which analysis of interviews undertaken in Phase One with ANPs formed the interview schedule for Phase Two with stakeholders. It begins with a reminder of the study's aim and objectives.

## 3.2 Aims and Objectives

### Aim

The overall aim of this research is to explore, compare and contrast the views of ANPs, managers, NHS leaders, commissioners and employers with respect to the current and evolving role of the ANP in primary care general practice regarding training, support, role development, governance and issues relevant to the ANP workforce. This study aims to develop insights into how the ANP role is currently practised, assess perceptions about ANP practice held by a range of stakeholders, develop a new understanding of the role, determine if the current systems of developing and supporting ANPs are fit for purpose, and make policy recommendations based on the findings.

### Objectives

- To determine the views of key stakeholders, commissioners, managers, GPs and nursing leaders with respect to the ANP role in primary care, future innovations and potential for cost savings and efficiencies.

- To explore the current working practices of ANPs in general practice, their drivers, barriers, influencing factors, limitations and boundaries.

- To determine how the ANP workforce views the evolving role of the ANP in general practice and what further developments they believe are required to meet patient demand.

- To understand not only the pressures upon ANPs and the nature of their evolving role but how these changes impact ANPs themselves on a personal, professional and group level.

- To explore the perspectives of NHS leaders, commissioners, managers and GPs with respect to the ANP role and to analyse the data for similarities and disparities.

- To determine whether there are any disparities between the views of commissioners and ANPs themselves around the role, its competencies, and potential innovations and cost efficiencies, and what implications these may have for workforce planning, training and role development.

- To make recommendations with respect to the future role of the ANP within general practice regarding training, support, development, cost savings, efficiencies and governance.

## 3.3 Theoretical location

All research is interpretive, guided by a set of beliefs and feelings about the world and how it should be studied (Denzin and Lincolm, 2011). These beliefs or *paradigms* are inclusive of ontology, epistemology and research methodologies. Creswell (2012) defined ontology as a set of philosophical assumptions about reality and the nature and characteristics of the world around us. Bryman (2012) described ontology as the philosophy of what we know, what exists and how we know it exists. Epistemology is the philosophy of knowledge, or more specifically, how we come to *know* something (Kraus, 2005).

According to Green and Thorogood (2014), research is aimed at producing valid knowledge about the world. As such, it is essential to outline the epistemological and ontological position of the researcher, thus making any source of bias, previously held values and assumptions more transparent. Qualitative research is never value free; however, Ormston et al. (2014) assert that such research can still aspire towards *empathic neutrality* wherein the researcher strives to be neutral, non-judgemental and unbiased in their approach. The current study aims to explore the role of the ANP within

UK general practice, its drivers, current situation, as well as the thoughts and feelings of ANPs, comparing these with those of commissioners, managers, workforce strategists, as well as NHS and nursing leaders.

In terms of ontology, this study embraces the views of participants with respect to their perceptions of reality, using their actual words as the primary source of data. Creswell (2013) and Charmaz (2012) both emphasise multiple forms of evidence in the themes generated from the research, using differing viewpoints, experiences and words as multiple realities. Charmaz (2012) goes further, highlighting that the researcher is part of the phenomena being researched in a qualitative study whilst refraining from introducing sources of bias or influence.

Epistemologically, this study contributes to the construction of new knowledge by recording the subjective experiences of participants, with the researcher attempting to enter their world and to see it from their perspective (Charmaz, 2012). Consequently, the research data informing this study is based on the individual, subjective views of its participants. To this end, the research data and subsequent knowledge development are based on the descriptions and experiences of ANPs working within general practice, how they perceive their roles, their day-to-day experiences, factors influencing change, stressors and how perceive their roles as developing, according to their own experiences. The same can be said of the perceptions of managers, commissioners, GPs, NHS leaders and nursing leaders with respect to their contributions to knowledge development around the ANP role, its development and future.

The interpretive frameworks for qualitative research are numerous. Denzin and Lincoln (2011) describe the aforementioned ontological and epistemological considerations as frameworks upon which research is built. Data collection and methods of analysis in quantitative research strive for objectivity. Corbin and Strauss (1990) suppose that pure objectivity in qualitative research is a myth. It is argued that the self, one's training, perspectives, knowledge and biases—those things that the researcher cannot help but bring to the research—are used to increase the researcher's insight and sensitivity, helping them to *tune in* to the responses of participants (Corbin and Strauss, 1990). Being aware of my own nursing background, working as an ANP and any assumptions or biases that might come with this as well as questioning my own perceptions and perspectives are useful strategies for developing research rigour and avoiding the fallacy of treating assumptions as facts (Mason, 2002), whilst remaining as open as possible to what is being said.

Quantitative methods were considered for this research but were ultimately rejected. As demonstrated in the literature review, qualitative methods have an established history with respect to the study of advanced practice roles (Williamson et al., 2012; Gardner et al., 2007; Tye and Ross, 2000; Rolfe and Phillips, 1997; Woods, 1999). These studies used interviews with employers, patients and ANPs to provide an in-depth understanding of the issues and the experiences of key stakeholders. A survey of ANPs, however, would not be an effective instrument by which to meaningfully ascertain their feelings, experiences, frustrations and thoughts about the future. Moreover, the efficacy of quantitative surveys is often limited by their reliability and validity. There are also potential issues around sampling, with respondents to surveys often not being representative of the workforce and having a vested interest in one aspect of the survey (Burns, 2000).

## 3.4 Qualitative Approaches

A qualitative research design using one-to-one semi-structured interviews was chosen for this study. Qualitative research has historically been employed in fields such as sociology, history and anthropology (Miles and Huberman, 2009), and is now increasingly popular in health and medical research. Data obtained via qualitative studies can be a source of well-grounded, rich descriptions and explanations of processes in identifiable local contexts (Austin and Sutton, 2014). The data used to inform qualitative studies tends to be non-numerical, concerned with the experiences and behaviour of the participants, describes the phenomenon being studied and how it impacts the participants and can often be generalisable as a theory regarding a wider population (Berg et al., 2012). Although qualitative methods have been used for centuries, albeit without formal recognition, it was not until the early 1900s that researchers began to reject positivism and the idea that there was an objective world necessitating empirical study. The idea of interpreting the subject personally, understanding the impact of the research topic on the individual and of studying human behaviours led to qualitative research methodologies becoming more rigorous, even if only being used alongside quantitative studies (Wolfensberger, 1994). Throughout the 1970s and 1980s, with the advancement of computers and methods of computer-aided analysis, qualitative research became increasingly widespread, resulting in the publication of qualitative research journals and the development of mixed-methods studies, challenging the thinking that qualitative and quantitative studies were incompatible (Babbie, 2014). There remains, however, widespread debate regarding

whether the two methods are compatible due to their differing ontological and epistemological assumptions (Charmaz, 2012).

Researchers using qualitative methodologies have a multitude of techniques at their disposal for the collection of data. These include interviews, observations, focus groups, shadowing and case study analysis. The semi-structured interview is common in qualitative studies. This method of data collection involves the interviewee answering a series of pre-set (but flexible), open-ended questions and is widely employed by various healthcare professionals when analysing the lived experience of patients or other clinicians (Corbin et al., 2008). Typically, the interview is conducted only once with each participant (except in the case of longitudinal studies) and commonly lasts up to an hour in duration. The interviewer uses open-ended questions to guide the process of capturing data and relevant responses, although there is always the potential for the interviewer to ask any number of possible follow-up questions.

Mason (2002) described qualitative research as flexible, fluid, responsive, data-driven and context-sensitive. As the collection of data continues, it may become necessary to change or adapt the interview talking points based on the data that has already been obtained depending on its importance or whether certain key issues have begun to emerge from the data. This enables the researcher to not only adapt each interview and series of questions to the specifics of the participants or the environment but to evolve the questioning and interview talking points based on previous data. The setting and context in which a participant addresses an issue is an important factor. ANPs working in different GP surgeries, with differing numbers of staff and patients, workforce strategies and patient demographics require that the research design be fluid and flexible. Ensuring an adaptive, context-specific, evolving line of questioning would be pertinent to this study as each participant will inevitably have their own unique interpretation, set of experiences and personal belief about the evolving nature of the ANP role and their current and future working practices. Unforeseen issues may emerge as data collection progresses; as such, the focus and line of analysis in the study may have to be adapted over time.

This study does not test any hypotheses, theories or baseline observations. The categories, themes and eventual theories are unknown at this stage. As such, it is the data that will eventually guide the development of theory. To this end, it is imperative that the interviews be flexible in their line of questioning so as to take the researcher wherever the data might lead. As such, the interview process evolved in unison with data collection and in response to the issues raised by participants. This process

inevitably shaped the second phase of data collection, with the findings of the ANP interviews being discussed with the second cohort of participants. As individual ANP roles and duties are heavily influenced by their GP/manager, local patient demand and the commissioning of local services in which ANPs operate, the views of those with influence over the direction of the ANP career path is crucial to understanding how the role functions, has evolved and is likely to continue to adapt. Nevertheless, it was necessary to draw comparisons between these two groups, hence the split-phase design of the research. Moreover, a simple survey would likely prove inadequate for capturing the subjective thoughts, feelings and emotions of participants, hence the need for a grounded theory design.

### 3.4.1 Grounded Theory

Grounded theory is an inductive method of data collection in which the data is sourced from observations or interviews before any theory or hypothesis has been identified. The data is gathered over time, with various themes, theories and levels of understanding emerging from the data as the process continues. The method was first developed by Glaser and Strauss (1995) in their 1965 study of dying patients to describe their thoughts and sense of awareness. The method was later developed further and is now used widely in health, social science, management and education research (Fletcher-Watson, 2013). Since its initial development, a range of grounded theory approaches have been articulated, including dimensional analysis, constructivism, situational analysis and classical grounded theory (Aldiabat and LeNacenec, 2018). Regardless of the form, grounded theory studies almost always consist of unstructured interviews, observations, participation or group discussions; data categorisation to identify common clusters of characteristics; are concerned with interactions and processes; and share a common approach to analysis (analysing the data throughout the collection phase) (Morse and Niehaus, 2009). Grounded theory emerged at a time (i.e. in the 1960s) when there was a general sense of research needing to move from data to theory so that new theories and levels of understanding could emerge. These theories would be specific, bound to the context from whence they had emerged and *grounded* in the data rather than from the analytical constructs and variables associated with pre-existing theories, as is typical of quantitative research.

The grounded theory process guides the researchers throughout the process of identifying categories, making links, establishing relationships and generating themes

from the data. Unlike other research methods, this process involves the researcher constantly moving between data collection and analysis, rather than waiting until all the data has been collected before beginning the analysis. The practice components of grounded theory, according to Glaser and Strauss (1971), include:

- Simultaneous involvement in data collection and analysis.
- Constructing analytic codes and categories from the data as opposed to any pre-conceived logically deducted hypotheses.
- Using the constant comparison method, which involves making comparisons throughout each stage of the analysis.
- Advancing theory development during each step of data collection and analysis.
- Memo writing to elaborate categories, specify their properties, define relationships between categories and identify gaps.
- Sampling aimed at theory construction, not population representativeness.
- Conducting the literature review after independent analysis.

The method *grounds* the research in the analysis with the aim of achieving data saturation (Sbaraini et al., 2011), having the ability to change the direction of the study by constantly encouraging the researcher to review earlier data based on later findings. Charmaz (2012) views methodology underpinning grounded theory as a set of principles and practices, not as a set prescription for how to conduct research, although the aforementioned aspects of the process are still held. A central theme throughout grounded theory is that the early *tentative* coding of the initial data is further refined upon the collection of subsequent data, with the process repeated until theoretical saturation occurs. As the data becomes more substantial and the study progresses, new unforeseen categories and themes can emerge to shape the structure of subsequent interviews. Figure 6 provides a basic representation of the grounded theory process of analysis based on three initial interviews.

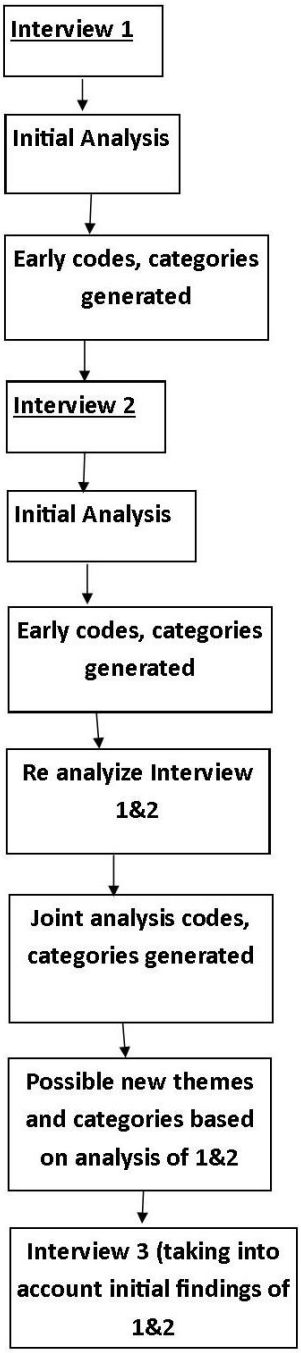


Figure 6. Grounded theory representation of the process of interview/data analysis.

Charmaz (2012) developed a revised version of grounded theory. Whereas Glaser and Strauss (1971) had argued that the theory emerged from the data as separate from the observer, Charmaz (2012) argued that data and theory were not discovered but were rather constructed through the researcher's past and present involvement and interactions with people, their perspectives and practices. This results in an interpretive representation of the world, not an exact version of it (Charmaz, 2012). This approach produces limited, tentative generalisations, not universal statements, and brings the

researcher into the analysis as an interpreter, not an authority who defines reality (Bryant and Charmaz, 2007). As an ANP, manager and business partner, and having worked with other ANPs for many years, this researcher is not *blind* to the phenomenon under investigation, nor are they without prior knowledge. This was the reason why grounded theory was ultimately chosen as the methodological design; the researcher not being a separate entity from the process or findings, and the findings and theories being grounded and emerging from the data. Through constant comparative analysis, memo writing and theoretical sampling, the categories and themes reflect and are grounded in the data, as opposed to being grounded in any pre-conceived notions. Thus, the grounded theory approach used in the present study was in accordance with the original principles of the methodology.

## 3.5 Methods

Charmaz (2012) supposes that all that the researcher learns and experiences in the research setting can be considered a source of data. Moreover, Glaser (2002) suggests that 'all is data'. In grounded theory, the researcher is part of the process and is active in the formulation of theory. The findings of the ANP interviews were to be compared and contrasted with the policymaker and stakeholder findings. To this end, the research was split into two phases:

**Phase 1:** ANP interviews in the north of England.

**Phase 2:** Interviews with commissioners, managers, GPs, NHS leaders, nursing leaders nationally.

Prior to the formal commencement of the research, a small pilot study was carried out involving three interviews. These interviews were conducted after having obtained full NHS research ethics and university ethical approval. Consent forms, information sheets and grounded theory methodology were all used to practice data collection and analysis, thus helping to elucidate any issues or roadblocks that the researcher might encounter moving forward with the study. This pilot was also used as an opportunity to rehearse interviewing and questioning techniques, to make a record of any interesting talking points and to test the equipment used to facilitate data collection. Following this initial pilot and analysis, the formal commencement of data collection could begin.

### 3.5.1 Participants in stage one

All 15 ANP participants were experienced practitioners, having been qualified for between three and six years. Data saturation (as discussed in section 3.5.11) was achieved after 15 interviews, following grounded theory principles. They all worked in multidisciplinary teams including GPs, practice nurses, ANPs, HCAs, administrative staff and pharmacies. All ANP participants were female, had qualified as generalist ANPs and had no particular specialism. The range of duties each ANP undertook ranged from acute and chronic condition clinics to leadership roles and responsibility for whole areas of healthcare such as end-of-life care and acute triage. Each participant was eager to share their views, and for the purpose of confidentiality will be listed by an anonymised name.

### 3.5.2 Participants in stage two

Ten semi-structured interviews were undertaken in phase two. Data saturation was achieved after ten interviews (as discussed in section 3.5.11). The participants were chosen via purposive sampling (Palinkas et al. 2015). This method is a technique widely used in qualitative research and involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest (Cresswell and Plano Clark, 2011). In this study, the participants were chosen because of the nature of their roles in leadership positions. The strategy undertaken was to select the participants based on their role, responsibilities and leadership positions, and none were personally known to me. Wherever possible, the most senior nursing representative was sought within the organisation, locally and nationally. Within CCGs and national bodies, the most appropriate individual was sought based on their role, responsibilities and willingness to participate. All the participants were invited via email to participate and were commonly in local or national leadership positions undertaking responsibilities concerning workforce planning or directly involving ANPs. To maintain confidentiality and anonymity, their job title or exact role is anonymised, instead using an alternative description of their role. To distinguish local from national leadership and policy makers, the findings will be displayed with the identifiers *local* or *national*. This is necessary as stating their exact position would enable them to be identified. The phase two participants are listed below:

*P15: (Local) CCG 1 Lead nurse*

*P16: (Local) CCG 2 Lead nurse*

*P17: (Local) Locality workforce strategist*

*P18: (National) RCN lead nurse representative*

*P19: (Local) CCG Executive clinical director*

*P20: (National) NHS England nursing representative*

*P21: (National) HEE workforce strategy representative*

*P22: (National) ACP education strategist*

*P23: (Local) GP*

*P24: (Local) GP*

### 3.5.3 Semi-structured interviews

Interviews were held at the participants' own workplace settings and at a date and time they found convenient. Several of the Phase 2 participants were interviewed via video conference using Skype at the participants' request. This method helped to overcome issues pertaining to the geographic distance between the researcher and the participants, as well as overcoming issues with the scheduling of interviews. Before each interview, each participant received an email with an attached Participant Information Sheet (Appendix 1), after which they were asked to sign and return the Participant Consent Form (Appendix 2). At the commencement of each interview, the participant was thanked for agreeing to take part in the research and there was a discussion on the background and reasons for the research, including my own experience and background. This helped to establish rapport with the participant and created an atmosphere where the participant felt comfortable. Participants were given the opportunity to review any of the information sheets or consent forms and to ask any questions. Two consent forms were signed, with the participant retaining a copy for themselves. Demographic information, qualifications, experience and the participant's location were not recorded at this point as this information was collected during the interview. Participants were informed that the interview would be recorded, with assurances given that any data collected during the interview would be anonymous. Moreover, participants were informed that they could stop the interview or withdraw from the study altogether at any time. No identifying information would be made

available to anyone outside the research and the participant's position or grade would not be identifiable in the write-up.

Interviewees were informed about the fluid nature of the semi-structured interviews. Although there were broad themes to discuss, the flow of the interview could change to accommodate whatever was being discussed or to reflect a particular topic that the participant wanted to discuss. A brief description of the nature of the grounded theory methodology was had regarding the evolving nature of the interview discussion points and focus. Once the participant was ready to proceed the interview could begin. No written notes were taken during the interviews such notetaking might have caused the participant to alter their responses, become anxious or may have caused the researcher to miss key pieces of information (Mason, 2002). A pre-formulated list of talking points was used to guide the interviews. This list of talking points was reviewed and adapted before each interview based on previous interviews and ongoing analysis (Appendix 3). The interview guides were also based on the literature review and the research aims and objectives, in line with the recommendations of Charmaz (2012) with respect to the development of an effective interview strategy. Immediately following each interview, notes were written regarding any thoughts, feelings, how the interview went, positives, negatives, initial queries regarding possible themes and ideas for the next interview.

The first talking point in each interview was always, 'Can you tell me about yourself, your role, your experience and where you work'. This often led to follow-up questions and discussions regarding the way in which each ANP and GP practice worked. Initial interviews involved broad, open-ended questions, such as the types of advanced roles, how participants' roles might be changing, what the future might hold and their current duties. This led to a more focussed line of questioning about the type of patients that the participants were consulting with, the degree of technicality and levels of advanced practice. Open-ended questions were used to avoid simple *yes* or *no* responses, to facilitate more detailed responses and enrich the data.

Another helpful, broad talking point following the opening question was, 'Could you describe a typical day' or 'What would be a typical morning for you'. This would often lead to prompts regarding a perceived *good* morning's consultations or a *bad* series of consultations and the level of skills and knowledge required to manage these. The responses to these openers provided information about the duties performed by the ANP, their interactions with patients, positive and negative aspects of their day and their level of autonomy. This naturally led to follow-up talking points and attempts to seek further clarification. By repeating participant responses and clarifying these points, the

researcher demonstrated active listening and engagement, as reflected in the following example:

> *Ok, you said some mornings are very taxing or demanding and at a high level. Could you go into a bit more detail on the type of patients you mean and how it affects you?*

Talking points used to bring the interview to a close usually revolved around the future for the ANP and any relevant national innovations or policies that might be aware of. This was not a personal question directed at the participant, but an attempt to identify a broader national view of the ANP role. These closing talking points should be seen as a winding down of the interview and an attempt to end on a positive note. This is in order to help the participant to move on from any feelings of anger, frustration or distress that might have been aroused during the interview (Arthur et al., 2014). Each interview lasted between 45 and 60 minutes after initial greetings, preparations and equipment setup. At the end of the interview, participants were asked whether there was anything they would like to add, had forgotten to include or any points they would like to go back to in more depth. On several occasions, participants declined these offers to provide further contributions, but then recapped what had been said and gave a brief overview of where they thought advanced nursing was heading, often in a more light-hearted and relaxed manner once they knew the interview was almost over. This ending discussion often lasted another 5–10 minutes and was still recorded. Once the recording had ended, participants were asked whether there was any aspect of the interview or response they would like to have omitted from the data, to which each participant declined. On four occasions the participant discussed general ANP issues or national strategies in a relaxed manner after the recording had ended before exiting the interview setting. Participants were asked if the researcher could take notes of this brief, informal post-interview discussion, to which each participant agreed. Each participant was thanked for their time, after which the researcher's personal contact details were highlighted on the information sheet.

### 3.5.4 Purposive sampling and inclusion criteria

The initial participant sample was purposefully selected (Charmaz, 2006). This was done to recruit ANPs who worked within general practice, had several years' experience and were willing to take part. No two ANP participants worked in the same practice and sites were located across a wide area of the north of England. Prior to recruitment, a

series of short presentations were undertaken at key events to raise awareness of the research, including QNI meetings, ANP forums, training days, locality meetings, workforce development events and other relevant meetings. Sampling from various locations resulted in a sample with a range of contrasting ANP experiences across a range of CCGs and practices, thus capturing a broad range of working models. Invitations were sent to potential participants via email, obtained by accessing the mailing lists of various ANP groups, forums and CCG lists. The inclusion criteria for Phase 1 were:

- An ANP working within a GP surgery,
- At least 2 years' experience,
- Working at an advanced level,
- Has prescribing rights and duties,
- Has undertaken a master's level degree,
- Willing to participate in a recorded semi-structured interview.

A participant information sheet was included in the email invitation, along with instructions on where to respond. Would-be participants were asked to include in their emailed responses where they worked and the makeup of their surgeries. Appropriate participants meeting the criteria were contacted by email and mutually convenient times, dates and locations were identified to conduct the interviews. A number of respondents did not meet inclusion criteria but were nonetheless keen to take part. These included ANPs who worked in hospitals, had only recently qualified or who were community-based nurses. Phase 2 participants were recruited directly due to the nature of their positions, these included NHS nursing leaders, an RCN nursing spokesperson, someone from the HEE responsible for nursing strategy, GPs willing to take part in the study and CCG commissioners. These were again recruited by email invitation. The QNI declined to take part on the grounds that they did not have anyone appropriate to speak about advanced general practice nursing. The Secretary of State for Health and the Minister for the Department of Health also declined to take part.

### 3.5.5 Sample characteristics

In total, 15 ANPs were interviewed across 15 sites in Phase One. All participants met the selection criteria and were unfamiliar with one another. Participants in Phase Two included two GPs, a CCG Director of Nursing, a CCG Executive Clinical Director, an

RCN lead nurse, NHS England nursing leader, a CCG workforce development strategist, HEE advanced practice workforce development representative and a Director of Advanced Practice Education Development.

### 3.5.6 Theoretical sampling

The focus of a grounded theory study is free to shift and evolve as the research progresses. The fluid nature of grounded theory studies is a reflection of the openness of the grounded theory design, which twists and turns according to the data being collected at the time (Sbaraini et al., 2011). The later sampling of participants should be theoretically orientated as opposed to variable and should be carried out as to add new information to the study, either to reinforce theories being generated or to expand upon an emerging theory which does not have a substantial evidence base (Charmaz, 2012). By testing a theory in the field through focussed sampling, early codes, categories and themes can be fully explored by collecting pertinent data from relevant sources. Such subtle phenomenon might be easily obscured in a randomised sample of participants. To demonstrate the process through which a theory has been developed, the researcher should pay attention to capturing the flow of theoretical sampling, thus demonstrating the build-up of theoretical insights and how these contribute to the formation of an abstract theory (Breckenridge, 2009). Concepts emerging from the coding of initial interviews are used to guide areas for further exploration in subsequent interviews. For example, codes and memos from interviews 1–3 identified issues around ANPs working alongside other ANPs and a feeling of support and guidance gained from this contact. Theoretical sampling was used to identify single ANPs working in GP surgeries to test emerging concepts. This sampling process ensured that only relevant data was being collected, helping to elucidate gaps in the emerging theory and guiding the researcher before moving on to the next source of data (i.e. subsequent interviews). As a result, it was not possible to plan the sources of data collection in advance as this issue was dependent upon whatever theory would emerge from the previously collected data (Glaser and Holton, 2004). Consequently, only two interviews were booked at a time, thus ensuring an opportunity to analyse the interview data and to reflect upon this data so as to guide the next round of data collection. This circular process continued until gathering fresh data ceased to provide any new theoretical insights or reveal any new theoretical categories—the point of saturation (Charmaz, 2012).

### 3.5.7 Memo writing

Memos are theoretical notes written by the researcher throughout the entire process of data collection and can be inclusive of analysis, code generation, concepts and theory discovery (Holton, 2010). These memos should be theoretically based and are concerned with the researcher's ideas about the emerging themes, categories, codes and their theoretical underpinnings on a conceptual level. Memos can guide the researcher through the data collection and analysis process, ensuring that they remain focussed on the original aims and objectives of the study, and can help to reduce the risk of bias (Sbaraini et al., 2011). Memos also act as a journal of the researcher's thinking throughout the research process and should detail the development of possible theories and explanations for what is being seen in the data. Memos can aid in the refinement of categories and concepts by testing early themes within the data and prompting the researcher to go back to the field to test these ideas (Charmaz, 2012). The researcher captures their initial ideas and process of theorising whilst analysing the data, thus aiding in the construction of emerging categories into theories. It is easy to become overloaded by conceptual ideas and thoughts about emerging theories whilst analysing the data (Glaser, 2013), and although there are no formal rules outlining what a memo should contain or how it should be formatted, the aim is to not let a thought or early idea around a theory become lost in the large amounts of data being presented.

In this study, memos were written in relation to the codes, comparing these codes with other codes in the data and theorising about emerging themes and categories. Emerging concepts were considered in memos, which naturally led to the next stage of analysis: category formation. Memos were also written immediately following each interview, detailing the researcher's initial thoughts, musings about possible theories, possible theoretical sampling requirements, the interview process and areas for further analysis. Lempert (2007) describes memo writing as the fundamental process of research engagement that results in the development of a grounded theory. An example of a memo is found in Appendix 3.

### 3.5.8 Recording and transcribing

All interviews were recorded on a digital Dictaphone. Whilst Glaser (1998) argues that the interview should not be recorded as it can result in the researcher being overloaded with unnecessary data and slows the data collection process, Charmaz (2012) suggests that written notes alone cannot sufficiently preserve participants' tone, tempo, silences and statements. Non-verbal cues such as smiles, frowns and head nods, were recorded later as memos or field notes. None of the audio recordings included any information allowing participants to be identified, ensuring anonymity.

Each interview was transcribed verbatim before any succeeding interview, thus allowing for initial coding and analysis. Transcription was carried out by an NHS secretary who was blind to any identifiable details. All pauses, laughs, sighs and any other inflexions were included.

### 3.5.9 Constant comparative analysis

Thematic analysis is one of the more common forms of data analysis in qualitative research (Guest, 2012). Although different versions of thematic analysis exist, the most commonly cited is perhaps the method developed by Braun and Clarke (2006). This method involves analysing the data in six phases: (a) familiarisation with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing the themes, (e) defining and naming themes and (f) finalising theory generation. Charmaz (2012) presents a similar model for thematic analysis in grounded theory, with stages inclusive of (a) gathering rich data, (b) coding, (c) memo writing, (d) theoretical sampling and sorting, (e) theoretical saturation, and (f) theory generation. This method is more appropriate to this study given the basis in grounded theory. Thematic analysis is principally used to generate themes within the data and then to integrate these themes for the development of theory. The aforementioned models were used to go beyond merely identifying common themes, phrases and words, but generate new theories, understanding and knowledge (Boyatzis, 1998). This process is inductive (i.e. the theories come from the data) rather than deductive (i.e. theories are pre-conceived and limited to one or two predetermined theories). The grounded theory method also involves constant comparison, with the data being subject to constant analysis as the study progresses, not merely analysing and moving on to the next interview.

The constant comparative method, as described by Glaser and Strauss (1971), is a method of establishing analytic distinctions and comparisons at each level of the analysis process. This is achieved by comparing all the data with all other parts of the data for differences, variations and similarities. Statements, codes and concepts are compared not only with different interviews but within the same interview (Charmaz, 2012). Interviews are subject to constant simultaneous analysis, with codes compared with each other as the research progresses. For example, once Interview 5 had been analysed and coded, interviews 1–4 were also re-analysed considering the new codes that had emerged from Interview 5. This process helped to shape the upcoming interviews and topics, as well as the theoretical sampling requirements.

### 3.5.10 Codes, categories and themes

Coding can be seen as the process of organising and sorting the data. Words and phrases are coded into keywords or short sentences, such as *stress*, *pressure*, *appointments* or *training*, which are later grouped into categories. The coding process in this study was inductive, using emergent or grounded codes (Braun and Clarke, 2006), rather than a pre-established list of codes. Whilst undertaking the systematic coding process, Charmaz (2012) advises that the researcher ask themselves the following questions:

- What is this saying? What does it represent?
- What is this an example of? What do I see is going on here?
- What is happening?
- What kind of events are at issue here?
- What is trying to be conveyed? (Not only the words but the meaning).

A word, short phrase or very short sentence is then assigned to the data item to answer these questions, which is then used as a *code*. These codes are then later grouped into categories; although as the study progresses and more information is made available, more codes are added and refined, not only to the new data but also to previously collected data, which is re-analysed and re-coded in light of more recent interviews. NVivo 12 software was used to aid in the coding of the data. NVivo is a qualitative data analysis software package produced by QSR International (2018). NVivo is designed for qualitative researchers working with rich text-based information where a deep level of analysis of large volumes of data is required (McNiff, 2016).

Coding was carried out word-by-word, line-by-line and statement-by-statement in order to fulfil two criteria for producing a grounded theory: *fit* and *relevance* (Charmaz, 2012). Fit is when codes are developed and grouped into categories that fit with and crystallise the experiences of participants. Relevance relates to the research offering and incisive analytic framework used to interpret what is actually happening and to make relationships between processes and structures more visible (Charmaz, 2012). The first step of the coding process involves the use of *open coding*, with no pre-set codes. This is a tedious line-by-line process of coding words, phrases and statements. During this process, the researcher is guided by the questions: 'What is this about?' and 'What is being referenced here?' This is followed by *focussed coding*, wherein the initial codes are studied and compared. During this step, many of the opening codes may be absorbed into focussed codes. According to Charmaz (2012), after establishing some strong analytic directions through the initial line-by-line coding, focussed coding is used to synthesise and explain larger segments of data. Focussed codes are then used to develop categories of codes.

Categories are describing words used to describe a possible concept or group of codes. When merging codes, commonalities may emerge which can indicate a category. The category is *filled* with codes and concepts used to verify its accuracy and its relationship to the data. These categories may be representative of the theoretical or substantive definition of what is happening in the data (Charmaz, 2012). Each category must earn its way into the analysis (i.e. it must be grounded in the data rather than being generated from the researcher's hypotheses and preconceptions) (Hallberg, 2009). An example of the process would be initial codes of 'More highly complex patients', 'Having to adapt to fewer GPs' and 'Getting more stressful', highlighting the changing nature of advanced practice, with these codes later being developed into focussed codes, such as 'Role change due to demand'. The category of *changing role* was developed following a process of constant comparison between codes and themes. Further analysis of the data around the theme of changing roles led to the development of further categories, such as 'Becoming more doctor-like' and 'Filling in the gaps'. An example of coding and category formation is found in Appendix 4.

### 3.5.11 Theoretical sensitivity and data saturation

Developing a grounded theory is dependent on the development of theoretical sensitivity (Glaser, 1998). Charmaz (2012) describes theoretical sensitivity as crucial in the application of grounded theory methods. The ability to generate concepts from the data and to relate them according to normal models of theory in general, and theory development in sociology in particular, is the essence of theoretical sensitivity (Glaser and Holton, 2004). Being constantly aware of the possible underpinning theories within the data is key to formulating a grounded theory, not simply coding the data and presenting the findings. Through the process of memo writing, constant comparison and being sensitive to emergent theories, the researcher begins to see the kind of categories that might be necessary for handling the data theoretically, thus informing their coding process and ensuring that any emergent theories fit with the data (Glaser, 1998). The process of developing theoretical sensitivity requires that the researcher undertake to study life from multiple vantage points, making comparisons, following leads and building upon ideas (Charmaz, 2012).

Knowing when to stop data collection in grounded theory is known as the *point of data saturation*. The criteria for stopping data collection are described by Glaser (1998) and Charmaz (2012) as when the properties of the theoretical categories are saturated with data. Rather than stopping when there are no new findings, in keeping with the grounded theory methodology, data gathering stops when no new properties of categories are found and when the categories account for what is seen in the data. An example of this is the category ‘Replacing GPs’, for which the codes included ‘Working at a higher level than before’, ‘Taking on new roles’, ‘Being asked to do something new’, and ‘Types of patients changing’. The focussed code was ‘Taking on a previously doctor role’. The properties of the codes, which were saturated, were factors contributing to the advancing role, extra training, financial reward, GPs leaving and being replaced by ANPs and autonomy. The properties of the category were tested at each stage of the process and proved to be applicable across all sites.

### 3.5.12 Rigour

Table 1 presents the criteria for grounded theory studies, as described by Charmaz (2012), aiming for credibility, originality, resonance and usefulness.

Table 1. Criteria for Grounded Theory Studies (Charmaz, 2012)

| | |
|---|---|
| **Credibility** | • Has your research achieved familiarity with the setting or topic?<br>• Is the data sufficient to merit the claims made? Consider the range, number and depth of observations contained in the data.<br>• Have you made systematic comparisons between observations and between categories?<br>• Do the categories cover a wide range of empirical observations?<br>• Are there strong links between the gathered data and your argument and analysis?<br>• Has your research provided enough evidence for your claims to allow the reader to form an independent assessment and to agree with the researcher's claims? |
| **Originality** | • Are your categories fresh?<br>• Does your analysis provide a new conceptual rendering of the data?<br>• What is the social and theoretical significance of the work?<br>• How does your grounded theory challenge, extend or refine current ideas concepts and practices? |
| **Resonance** | • Do your categories portray the fullness of the studied experience?<br>• Have you revealed both liminal and unstable taken-for-granted meanings?<br>• Have you drawn links between larger collectivities or institutions and individual lives when the data so indicates?<br>• Does your grounded theory make sense to your participants or to people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds? |
| **Usefulness** | • Does your analysis offer interpretations that people can use in their everyday worlds?<br>• Do your analytic categories suggest any generic processes?<br>• If so, have you examined these generic processes for tacit implications?<br>• Can the analysis spark further research in other substantive areas?<br>• How does your work contribute to knowledge? How does it contribute to making a better world? |

Whilst checklists and strategies for ensuring rigour can assist in assessing the quality of the research, they can also encourage a mechanistic and protocol-driven approach to the research (Greenhalgh, 2012; Barbour, 2001). The question of verifying grounded theory studies has often proven problematic (Bryant and Charmaz, 2007). Strauss

believes that grounded theory is a method of verification, whilst Charmaz (2012) views the method as a form of jointly constructed theory for what was happening at that particular time (Charmaz, 2012). As such, this study uses the criteria outlined by Charmaz (2012) to appraise the quality of the research:

**Credibility:** Familiarity with the topic was gained through 5 months of interviewing and interacting with participants and collecting and transcribing the data using the constant comparative method, becoming intimately close to the data and topic. The claims and findings emerged from the data—the in-depth interviews from multiple viewpoints and perspectives that provided rich information. This process of triangulation, in conjunction with selected coding, categories and theoretical concepts, ensured strong links between the analysis and the rational development of arguments. This process also provided links between the gathered data, the findings and the analysis. Regular input from academic supervisors provided guidance and feedback on the process, thus ensuring the appropriateness of the steps taken. The criteria for ensuring credibility in any qualitative study, is the demonstration of transferability, dependability and confirmability (Korstjens and Moser, 2018).

**Originality:** The first pass open coding of the data, followed by focussed coding, ensured the development of new accurate codes based on the actual responses of participants. Categories developed based on these codes led to concepts that expanded upon existing ideas around general practice advanced nursing. These concepts are based on multiple vantage points of ANPs, not only from these nurses themselves but also from commissioners, managers and leaders. The identification of paradoxes and discrepancies between these views was unintended but nonetheless reflects the data and analysis.

**Resonance:** To achieve resonance, the focussed codes and categories were formulated to ensure that they would account for the actual perceptions of participants; as such, special attention was given to the most significant and most frequently occurring codes (Charmaz, 2012). Comparing all data with data ensured that the main categories represented the views of all participants and all sites. Opposing views and paradoxes provided insights that participants may not have previously been aware of.

**Usefulness:** The usefulness of the research is evident as it adds to the body of knowledge around advanced practice and the evolving nature of the role. The multiple viewpoints of nurses, managers, commissioners and strategists highlight disparities between key stakeholders and nurses as to the direction of travel. The study raises issues around titles, protections, what it is to be a *nurse* and the future for the role. The

aforementioned criterion was referred to throughout the research, providing a guide for the grounded theory process from where the codes, categories and concepts were developed.

Lincoln and Guba (1985) offer criteria for evaluating and conducting qualitative research based on the rigour and validity commonly associated with quantitative research. As displayed in Table 2, they replace traditional quantitative terminologies, such as *validity*, *reliability* and *generalisability* with their own taxonomy for qualitative research.

Table 2: Qualitative Research Evaluation (Lincoln and Guba, 1985)

| **Quantitative Research Terminology and Application to Qualitative Research** | **Alternative Terminology Associated with Credibility of Qualitative Research** |
|---|---|
| *Validity*<br>The precision with which the findings accurately reflect the data. | *Truth value*<br>Recognises that multiple realities exist; the researcher's outline personal experiences and viewpoints that may have resulted in methodological bias; clearly and accurately present participants' perspectives. |
| *Reliability*<br>The consistency of the analytical procedures, including accounting for personal and research method biases that may have influenced the findings. | *Consistency*<br>Relates to the *trustworthiness* by which the methods have been undertaken and is dependent on the researcher maintaining a *decision trail*; that is, the researcher's decisions are clear and transparent. Ultimately an independent researcher should be able to arrive at similar or comparable findings.<br>*Neutrality (or confirmability)*<br>Achieved when truth value, consistency and applicability have been addressed. Centres on acknowledging the complexity of prolonged engagement with participants and that the methods and findings are intrinsically linked to the researchers' philosophical position, experiences and perspectives. These should be accounted for and differentiated from participants' accounts. |
| *Generalisability*<br>The transferability of the findings to other settings and applicability in other contexts. | *Applicability*<br>Consideration is given to whether findings can be applied to other contexts, settings or groups. |

The Lincoln and Guba (1985) criteria were applied to this research throughout. This reflective process ensured credibility, reliability and consistency by applying their qualitative measures to the research; consistency, neutrality and applicability. The research is credible and applicable as it investigates current practice, obtains real-world experiences from ANPs and their policy makers, and makes recommendations for practice and policy.

### 3.5.13 Bias

The process of qualitative data analysis is obviously open to bias, which risks the validity of the overall research. Being able to free oneself from one's pre-conceived notions and beliefs is impossible (Thomas and James, 2006), and no piece of research is ever completely free from potential biases or unconscious influences (Nobel and Smith, 2015). Qualitative research is particularly criticised for being susceptible to researcher bias for reasons such as the perception that qualitative methods are lacking in scientific rigour, a lack of transparency and that the findings might merely be a collection of opinions (Charmaz, 2012). Research validity is a broad term used to demonstrate the strength and legitimacy of the methods and findings—validity referring to the integrity and application of the methods undertaken and the precision with which the findings accurately reflect the data (Long and Johnson, 2004). Not introducing or limiting researcher bias is essential to ensure validity.

The strategies to achieve consistency, reliability and validity, whilst minimising researcher bias are discussed widely in the literature and have been summarised by Nobel and Smith (2015) below. This summary includes recommendations by Thomas and James, (2006); Long and Johnson, (2004); Morse et al. (2002) and Slevin, (2002):

1. Accounting for personal biases which may have influenced findings.
2. Acknowledging biases in sampling and ongoing critical reflection of methods to ensure sufficient depth and relevance of data collection and analysis.
3. Meticulous record-keeping, demonstrating a clear decision trail and ensuring interpretations of data are consistent and transparent.
4. Establishing a comparison case/seeking out similarities and differences across accounts to ensure different perspectives are represented.
5. Including rich and thick verbatim descriptions of participants' accounts to support findings.
6. Demonstrating clarity in terms of thought processes during data analysis and subsequent interpretations.
7. Engaging with other researchers to reduce research bias.
8. Respondent validation: includes inviting participants to comment on the interview transcript and whether the final themes and concepts created adequately reflect the phenomena being investigated.
9. Data triangulation, whereby different methods and perspectives help produce a more comprehensive set of findings.

Although there is no universal terminology or criteria with which to evaluate qualitative research (Smith and Nobel, 2015), the researcher for this study strived to remain

authentic, neutral and relevant. By adopting the aforementioned steps for achieving consistency, reliability and validity in research, the researcher undertook to limit sources of bias and to minimise external sources of influence on the data. Ensuring the credibility and accuracy of the data, ensuring transparency, reducing bias and preparing for the possibility that this research might be used to pave the way for future workforce planning, training and support for ANPs is of paramount importance.

### 3.5.14 Reflexivity

Researchers, not participants, are obligated to be reflexive regarding what they bring to the scene, what we see and how we see it (Charmaz, 2012). The researcher's stance is paramount in grounded theory as the idea is to remain open to what is actually happening and not to allow pre-conceived hypotheses or biases to alter the data (Glaser and Holton, 2004). Personal reflection is required throughout the process, not only upon completion (Pillow, 2003). My own personal thoughts, pre-conceived ideas and concerns (both as a researcher and as an APN) were recorded at the commencement of the research as field notes. These were referred to throughout the process. One personal concern was the fact that I am a practising ANP and how this would affect data collection, interpretation and my interactions with participating ANPs. Although none of the participants were known to me prior to the research, they were made aware I was also an ANP. Holton (2007) suggests the researcher should not enter the research with any pre-conceived protocols, problem statements or having carried out an extensive review of the literature. Dey (2007) advocates an opposing view—that ideas immediate to the researcher can provide useful guides to the analysis process. Charmaz and Bryant (2007) suppose that anyone initiating a research study will most certainly have pre-conceived ideas relevant to the topic, arguing that these pre-conceived ideas should not be ignored. This provided reassurances that my prior knowledge was acceptable in grounded theory. Whilst my professional background allowed me to locate myself within the research, I was mindful not to superimpose my perceptions on the narratives gained from the interviews. Through maintaining a research diary, memos and reflections, the emerging concepts were grounded in the data rather than any preconceptions.

The idea of travelling around interviewing a wide range of participants was daunting at first. I was concerned about the lack of interest and with how I would go about accessing sites. The Health Research Authority did not require any prior access

limitations or CCG agreements as the study had no financial impact. Negotiations around access were done directly with participants via email. Each agreed to take part based on their availability, usually at lunchtimes, at the end of a working day or, on some occasions, on their days off work in their own time, factors for which I am very grateful. The responses to the email invitations were substantial. This was surprising and made me wonder whether the ANPs had something they wanted to say, another factor which appeared daunting at first, as a weight on my shoulders to make their views count for something. ANPs started to share the email invitation with other ANPs in their networks and, following their interviews, recommended other ANPs who they felt 'Would have a lot to say'. Although I am grateful for these actions, this had the potential to introduce bias and the sample becoming non-random, so I did not include anyone recommended by ANPs in the study. The final list of ANP participants included no-one who had any knowledge of other participants and they were not known to each other. My personal confidence grew following discussions with other students, my supervisor and after the pilot study. I felt that the Phase 2 interviews with nursing leaders, managers and commissioners was a more careful process than with the ANPs. I did not want to approach the interviews with the idea that I was simply putting all the views of the ANPs to them and asking, 'What do you think?' Broadly, the topics for discussion would be the same, although the key categories from Phase 1 would sometimes require a more careful line of questioning and diplomacy. For example, there was a strong feeling amongst many ANPs that the 2019 GP contract was a missed opportunity for them, leaving them feeling left out. When discussing this with the actual stakeholders in this contract, it was necessary to parse the wording of these discussions very carefully; as such, a well-planned approach was required.

During the data analysis process, there was an awareness of not wanting to make the data fit into pre-conceived codes (Charmaz, 2012). The process from focussed codes to category formation was based on the frequency of occurrences and not on any preconceptions, although empathising with the participants' reactions on various occasions was natural. The following is an example of a memo regarding 'threats to the role' following an interview:

> *This ANP works with multiple other ACPs (paramedic, pharmacy and physio) in a large practice. She didn't have any issue at all with the ACPs and didn't see a threat to her role, although she did have to use the ACP title and not ANP. She was practising at a lower level than ANPs who work without ACPs but didn't perceive this. Are these linked? Do nurses working with other ACPs naturally drift to a lower level of working? Are ANPs feeling threatened by ACPs due to*

*turf wars or fear of being left behind and is this accurate? Needs testing in upcoming interviews. Sample ANPs who work with and without ACPs.*

This memo highlights my own thinking and theoretical sensitivity. It also demonstrates the theoretical sampling of further ANPs who work with and without ACPs to test the data. Bryant and Charmaz (2007) describe reflexivity as the researcher's efforts to scrutinise their own research experience, decisions and interpretations in such a way that it brings the researcher into the process and allows readers to assess how and to what extent the researcher's own interests, positions, and assumptions may have influenced the research. Honest and accurate memo writing is an important aspect in the process of reflexivity and is a route to which self-awareness can be expressed (McGhee et al., 2017). Reflexivity is used as a function to improve the quality of the research (Mason, 2002).

My own experience of having worked as an ANP for many years, of managing other advanced nurses and participating in workforce strategy groups required reflection and reflexivity when approaching and undertaking the research. A personal research diary, memos and a reflexive approach ensured that my own thoughts and beliefs would not impact the interviews. The interview questions and talking points were guided by the data and the practice of constant comparative analysis, not by my own preconceptions. Although it is impossible to erase prior knowledge and experiences, they should not negatively impact the findings or introduce a source of bias into the data collection and analysis (Bryant and Charmaz, 2007). My own thoughts and beliefs prior to the commencement of the research included thoughts around:

- ANPs taking on more duties,
- A mixed picture of ANP roles across practices, and
- How willing nurses might be to undertake additional roles if they are appropriately rewarded and feel secure.

I was unsure how the above related to patient demands, employer pressures, national strategies or local service improvements. The initial talking points in the interviews needed to cover a broad range of issues before any initial analysis which would guide subsequent interviews. Open-ended, unbiased questions were used to avoid any conscious or unconscious influence. Reflective research diaries and memos were used to ensure that I was constantly aware of my thinking processes and methodological approach.

## 3.6 Ethical Considerations

Permission to carry out the research was sought from the University of Bath, Research Ethics Approval Committee for Health and the NHS Research Ethics Committee via the Integrated Research Approval System. A favourable response, with ethical approval granted, was obtained in early 2019 from both sources (appendix 5 & 7). Sponsorship from the university was also granted (appendix 6). Formal access to the research sites was not needed from the Integrated Research Approval System and each participant could be contacted and interviewed at their own discretion. None of the participants knew each other and they were interviewed on a one-to-one basis. I followed the ethical principles of autonomy, justice, beneficence and non-maleficence (Beauchamp and Childress, 2001), with any known risks brought to the participants' attention. All data was anonymised to protect the identity of participants and to maintain their confidentiality. At the beginning of each interview, the participant was made aware of their rights to anonymity and the confidential nature of the research, and that an NHS secretary might be tasked with transcribing the recording, this secretary themselves being bound by NHS confidentiality policies. Fully informed written consent was obtained prior to any data collection; as such, participants took part of their own free will and were free to withdraw at any time. Whilst maintaining participants' confidentiality and anonymity, provisions were made for any adverse events or serious disclosures of unprofessional conduct. These provisions were given favourable approval by both the university and NHS research ethics committees.

## 3.7 Confidentiality, Data Storage and Anonymity

Digital audio recordings were securely stored on an encrypted, password-protected device. This was then transferred manually to an encrypted PC which was password protected in a locked room. No identifying information was used in the filename of the recordings, with only an interview number being used. This number corresponded to the signed consent forms, which were also stored in a locked cupboard within a locked office. Once the recordings were transcribed and checked, the audio recording was deleted. The physical transcripts will be stored securely for 10 years in line with university policy.

The identity of the participants is known only to the researcher. No identifiable information was recorded in any way. Participants were informed that their confidentiality would be maintained, and their responses anonymised to prevent any attempts to identify participants (Burns, 2000). All confidentiality, data storage and protection practices within the research were in line with University of Bath policies and had received favourable approval from both the university and NHS research ethics committees.

## 3.8 Consent and Gaining Access

Marshall (2011) suggests that human actions are significantly influenced by the settings in which they occur; as such, behaviours and interactions should be studied in their real-life situations. The setting for the interviews was an important factor to facilitate the provision of rich, useful data. All ANP interviews were undertaken in their place of work, in the ANPs own office. Only three of the nine Phase 2 participant interviews were conducted via online video conferencing with audio recording (still on a digital Dictaphone). Full informed consent was obtained verbally and by written consent forms (Appendix 2). Preparations were carried out to ensure no interruptions occurred in the interviews, with ‘Do Not Disturb’ signs being placed on doors. Formal access approval was not required from NHS health research as no costs were involved. Each ANP was responsible for arranging a time and date at their choosing, with the approval, if required, of their manager. Upon arriving at each location, I presented formal identification (NHS identity and university student ID) and discussed with the participant the identification and reference numbers for the formal ethics approval and who to contact should they have any questions.

## 3.9 Summary

This chapter has described the research process for this study, a qualitative grounded theory methodology. This chapter has outlined and provided a justification for the dual approach of interviewing ANPs and NHS leaders, commissioners and managers, split between two phases, to provide multiple perspectives on the research topic, thus contributing to the validation design. Efforts to ensure reliability, originality and resonance throughout the entire research process have been addressed in reference to

the Charmaz (2012) criteria for ensuring rigour. The following two chapters will present the findings from each group of participants.

# Chapter 4

# Findings and Analysis

## Phase 1: Interviews

## 4.1 Introduction

Before undertaking this research, my view of ANP practice was based on my own experiences, speaking with ANPs in a single organisation and hearing anecdotal stories at meetings, forums and training events. I felt that my role was changing as a result of both increased demand and GPs retiring and not being replaced. This was the sum of my thinking around the ANP in general practice, but I wanted to explore in more depth how ANPs are dealing with these changes and any other issues they may be having. I also wanted to question key stakeholders on their views of the role and how they see it developing. During the data collection and analysis stages, it was apparent that my original suppositions about the changing role of the ANP were supported, but that there was much more to the changes than I had anticipated.

Three major themes emerged from the analysis of the ANP interview data:

*1. Changing role*

*2. National strategy*

*3. Role identity*

The first of these, *the changing role*, suggests that ANPs in general practice recognise that their role is changing and is being used to 'fill in the gaps' in service provision. The gaps are perceived to be a direct result of GPs leaving or retiring and not being replaced like-for-like, due to either recruitment problems or a strategic decision to replace the vacant position with an ANP or ACP. ANPs were experiencing a lack of direction and feeling underappreciated. Filling the gaps in GP numbers also resulted in concern around role identity: is what they are doing still nursing or more of a medical type of role?

A perceived lack of a *national strategy* was the second major theme. ANPs felt their voice was not being heard or they did not have a 'seat at the table' when decisions around general practice strategy were being developed. Many participants mentioned the 2019 GP contract as a key factor in this perception. This was also linked to the

ongoing development of the ACP multi-professional role, of which nurses are key members.

The third major theme, *role identity*, shows that varying professions being classed as ACPs was a key factor in the perception by ANPs of advanced nursing being threatened by other advanced professions, and of nursing contributions to the consultation and patient care being lost. Each theme will be discussed in detail, while table 3 provides a visual representation of the themes and categories with corresponding examples of supporting verbatim quotes. Including a visual representation of themes, categories and examples of corresponding direct quotes is a method of providing a visual link between these themes and the participant responses (Burnard et al, 2008). Each theme is discussed with participants' individual voices, journeys and experiences traced through the data. Figure 7 shows the final data structure, highlighting the categories, themes and grouped codes from which the findings were developed. Figure 8 shows a visual representation of the final themes, with subcategories also listed. To confirm the trustworthiness of the data and emerging categories, participants were sent copies of the grouped codes and early categories as shown in Figure 7. This ensured that the concepts and themes resonated with the participants and they agreed with the findings.

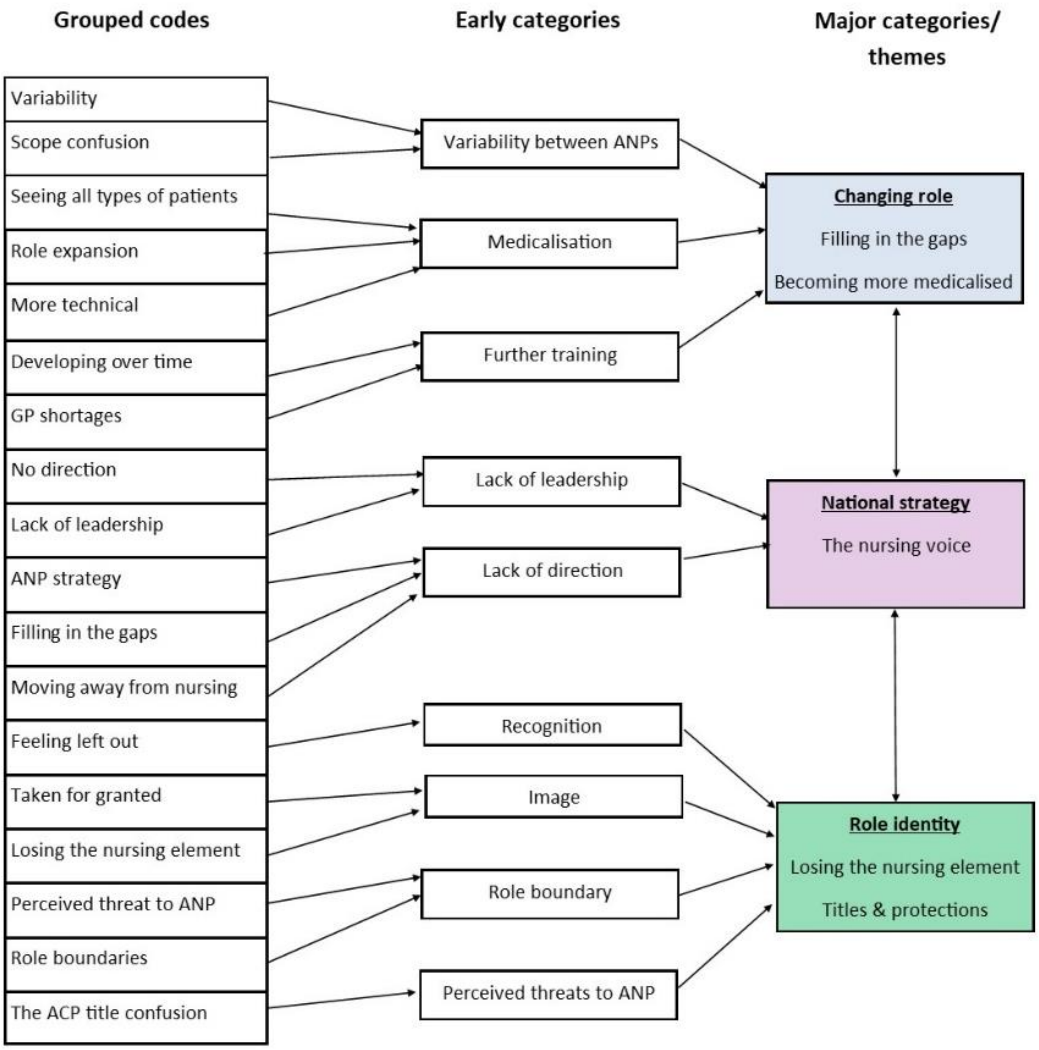


Figure 7 – Example of category formation – Phase 1

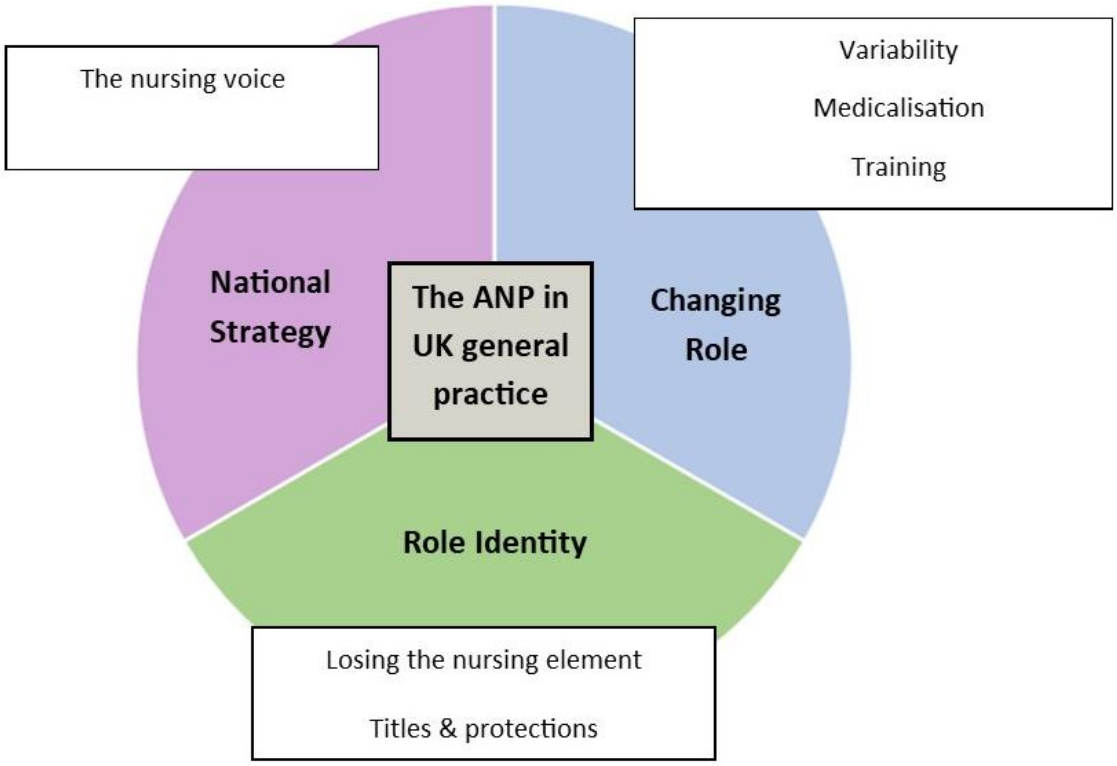


Figure 8 – Visual representation of the themes and categories – Phase 1

Table 3 – A visual representation of the themes and categories – Phase 1

| Categories and grouped codes | Examples of representative data |
|---|---|
| **CHANGING ROLE** | |
| **1: Variability between ANPs** | |
| A: Variability | *A: "It's variable because there's people using the title that aren't fully trained and qualified. The job description is vague as well."*<br>*A: "Some ANPs refuse to see this and that, like babies or palliative care, they shouldn't be able to do that. They're more like minor illness practice nurses."* |
| B: Scope of practice | *B: "You can take the role as far as you want to really, there's no limits it seems like, because no one really decided what the scope is."*<br>*B: "I'll only see and do something that I'm comfortable and trained in. Some ANPs do all sorts of advanced stuff like minor ops and triage and running whole services, so it's like it's up to them and their employers really."* |
| **2: Medicalisation** | |
| C: Seeing all types of patients | *C: " There's absolutely no difference between what a proper ANPs sees and what a GP sees anymore. Not here anyway."*<br>*C: "Anything that comes through the door. All ANPs here see anything and everything but that's not how it used to be. We used to be more minor illness and stuff like that."* |
| D: Role expansion | *D: "I'm doing a lot more. I've just done a contraceptive implant course to do that so I can take over from the GP doing it."*<br>*D: "I think we just respond to what's needed. Nursing's always done that. When there's less doctors, nurses take over."* |
| E: More technical | *E: "Nowadays it's all about tests, results, scans, bloods and all that. You have to be a lot more technical and medical in your way of thinking."*<br>*E: "It's more advanced now because the patients are more clued up on things. They come with printouts from Google of their likely diagnosis, so we have to be a lot more scientific and able to deal with all the tests and results and scans and all that."* |
| **3: Training** | |
| F: Developing over time | *F: "We all have to train in new skills all the time to keep up to date. But we've also got to learn new skills to take on new roles."*<br>*F: "Nursing's becoming more and more advanced all the time I think. Even nurse training is now talking about basic prescribing and ordering tests, so ANPs have to do even more."* |
| G: GP shortages | *G: "It seems like every time a GP leaves who's had a special interest in something, an ANP has to then train in that area and take it over."*<br>*G: "A GP recently left who did all the smears and swabs, women's health stuff. I'm now on a training course to take this role over [laughing]."* |
| **NATIONAL STRATEGY** | |
| **4: The nursing voice** | |
| H: Lack of direction | *H: "There might be some direction and strategy but no one knows about it. ANPs on the shop floor I think are unaware of where we're going to end up or who's looking after us."*<br>*H: "With ACPs and ANPs and other new roles, where's the nursing backup and people shouting for nursing?"* |

| | |
|---|---|
| I: Lack of leadership | *I: "We were all talking the other day about the new roles and the new contract. We've been totally let down and forgotten about."*<br>*I: "The NMC and RCN are a bit pointless when it comes to sorting the ANP out. Doctors and pharmacists have really strong people protecting them but we can't even make sure nurses who call themselves ANP are actually qualified."* |
| **ROLE IDENTITY** | |
| **5: Losing the nursing element** | |
| J: Role boundaries | *J: "A lot of patients don't really see a difference now. If you look and act like a GP they expect the same level of care. We're doing more doctor tasks so patients naturally get confused."*<br>*J: "We're all stepping on each other's toes a bit but it's working here so far. I do wonder how far we'll go though, into more of a medical type practitioner rather than nursing."* |
| K: Perceived threats to ANP | *K: "I'm a nurse and proud to call myself ANP. The new training and role is all about ACP and it's confusing what background they are. We're all now just called the same thing and do the same, so it's like where does the nurse come into it?"*<br>*K: "The new thinking this month is paramedics doing visits and pharmacists, all being ACPs. There won't be an ANP soon, just everyone doing the same as an ACP."* |
| **6: Titles and protections** | |
| L: Recognition | *L: "We really need a proper register for ANPs, and anyone who is just doing the basics and minor illness shouldn't be allowed to call themselves ANP."*<br>*L: "There's never any publicity or media coverage of ANPs in hospital or surgeries. We're classed as practice nurses, so everyone naturally thinks about dressings, injections, pill checks, baby vaccinations and all that. Whereas in reality we're doing most of the same GP roles."* |
| M: Image | *M: "Our image is still mixed. The patients see us as doctors doing the same things, but the media and commissioners see us as normal practice nurses as an add-on to the GP."*<br>*M: "I tell patients I'm a nurse, and on the way out, they all say, 'Thank you, doctor.'"* |

## 4.2 Theme 1 – Changing Role

All participants started their narratives with a description of their current role, their prior experience and their daily duties. They had all followed the traditional pathway of nurse training, qualification, and a period of consolidation, followed by further training in advanced practice:

> *Ann: I'd been a community matron for a while after qualifying and then working as a district nurse. After I did the ANP training as a matron, I went to work in a GP surgery and then worked my way up doing extra courses.*
>
> *Jane: I worked as a paediatric nurse for many years after qualifying. I wanted something different, so I went to work in a GP surgery and then did the ANP training. I now see all ages and anything that comes in.*

Throughout this time, they had experienced substantial changes within the NHS, primary care and general practice, all while undertaking further qualifications in areas such as family planning, respiratory and cardiac disease management, diabetes, palliative care and minor surgery. They had witnessed, in various settings, nursing taking on more medicalised duties and nurses seemingly eager to adopt new roles. This was also evident in their current roles as ANPs within general practice, as Carly and Debbie elaborated:

> *Carly: Not only with ANPs in surgeries but over my whole career, I've seen nurses doing more and more high-level type stuff over the years. Nurses are always keen to take on more technical and doctor-like duties, aren't they…It seems like a status thing or moving away from the bedside holding a patient's hand to more medical type things.*
>
> *Debbie: I've seen nurses in surgeries doing more and more things. The HCAs are now doing what practice nurses did five years ago, practice nurses are doing what ANPs first did, and ANPs are working like GPs now.*

They were keen to discuss their experiences of the role becoming more medicalised, seeing a wide range of complex conditions and having to develop and evolve to meet the changing needs of patients. Participants provided a description of more than a role merely changing over time, but one that was adapting to both increased demand and staff changes and evolving into something that may not entirely be a nursing role as a result. Three major categories are encompassed within the 'changing role' theme. Nurses, by training, are used to communicating, listening, and seeing beyond the initial problem the patient presents, in a holistic manner. This was seen to be changing within the ANP area of nursing, with a common description of the current role being more task-orientated and adopting a 'tick box' approach to patient care. This was seen as a more medical type model, an aspect with which participants were not entirely comfortable:

> *Adelle: I'm a nurse and proud to tell my patients I'm a nurse. Most of the time, though, they don't know any difference between me and a doctor. If I'm on visits or even seeing someone here, they always walk out saying, "Thanks, doctor," even though I've told them I'm a nurse. It's the changing role and manner we have to adopt, I think. I'm not comfortable being referred to as a doctor, but all ANPs have to act like it now though to do the job.*

There was an apparent link between the role changing and "*acting like a doctor*" (Adelle). Although the participants were aware of the increasingly complex nature of their role, they were also aware of the changing status, as Mandy elaborates:

> *Mandy: We are seeing more and more complex type patients and as a result I think we have to behave in a different way. We can't just hide behind the nurse uniform and run to a GP all the time, usually 'cause there isn't a lot of GPs about. We're taking on a lot more so we have to behave as autonomous*

*practitioners and equals, in a way to a GP cause we're doing mostly the same job.*

The above response recognises the changing role of the ANP, not only the change to the types of patients and the complexities, but changes to the demeanour, actions and responsibilities that follow. In addition to this, ANPs were retraining in specific areas to take on new practices. The requirement to undertake further training courses to expand their advanced roles was a common theme in the interview data. Beyond the prudent keeping up to date with prescribing, guidelines and interventions, ANPs were undertaking specialist courses and training to expand their role further. This was often as a result of a GP retiring or leaving who had had a special interest in a certain area, and the ANP then inheriting this role:

*Sue: We're training on different things all the time and keeping up to date. Because the staffing levels are changing and not as many doctors about, we have to do more training to be able to look after the patients. Even practice nurses are doing extra courses.*

The ANPs were keen to expand their role and train in new areas, often taking over an aspect of GP practice as a result of a GP leaving or retiring. A related aspect of change was that the role was seen to be lacking a clear scope, not only between surgeries and areas but also between individual ANPs, with confusion around exactly "how far can we go?" (Jane). As the pace of change to the workforce intensifies, confusion around the scope of practice was seen to be linked to this. Individual ANPs may retrain, take on new areas and innovate, and this led to a wide variety of practices amongst ANPs with no clear strategy, other than filling in the gaps in service provision and expanding their roles. They spoke of becoming increasingly established as a central role within general practice, but also of general practice nurses taking on more minor illness. This is an interesting area for analysis as not only were ANPs seen to be expanding their practices to accommodate demand and gaps in provision, they reported that their practice nurse colleagues were also seeing their roles develop. This appears to result in some nurses calling themselves ANPs but working at a lower level, hence the variability in the types of duties undertaken:

*Carly: The normal practice nurses are sometimes going on minor illness training, which is about five days long. They're then coming back and seeing things like sore throats, earache and that kind of thing. This usually means that ANPs are then seeing more complex stuff if all the minor stuff is going to them. I'm not sure a five-day course means you're ok to see all the minor ailments though.*

*Debbie: There's the stories of practice nurses going on minor illness courses and seeing sore throats. It just demeans the role and makes it hard to know what you're meant to be doing, especially for GPs 'cause they get confused.*

The above two quotes demonstrate the confusion around advanced nursing and the ANP role and the point where the former turns into the latter. Carly describes the minor illness nurse as being something separate to the ANP, whilst Debbie considers both being advanced nursing but with possible differences in scope and titles. This confusion possibly adds to the issue of a lack of scope and recognition, a problem that is becoming more apparent as the role develops further. Participants viewed these issues as also being linked to individual demands on the surgery and the ANP's own competencies and experience. If one GP practice required training and development in a certain area, then the ANP would pursue this and extend their scope, leading to variations in practice amongst the wider workforce. Most were frustrated that some ANPs were not perceived to be working at an adequately advanced level:

> *Lindsay: You do find some ANPs working at a low level, messing around seeing only sore throats, coughs, colds… boils [laughing]… and then refusing to see children and other more serious stuff. I don't think that's really being an ANP, and there should be some system to stop it, I think.*
>
> *Laura: It gets me really mad when there's a so-called ANP only seeing this and that, refusing to see kids, no mental health, no gynae. If you're calling yourself ANP and getting paid, then do the work.*
>
> *Joanne: There really needs to be a standard of what ANPs see. Practice nurses seeing minor illness isn't being an ANP. If the practice needs some minor illness work to be done, then fine, but don't think they're ANPs.*

The above three responses reflect the disquiet amongst the ANP profession regarding a lack of protections around practice and titles as their role changes and develops. The ANPs felt that the inadequate protections for qualified ANPs and the variability in the role were factors preventing ANPs from being fully recognised as independent practitioners capable of dealing autonomously with a wide range of conditions:

> *Rachael: I think that if everybody's doing different and using the ANP title whenever they want… doing minor illness and refusing other stuff, then it just makes it harder to be taken seriously. GPs and managers get confused between practice nurses, ACPs, ANPs, and I think some worry about it. I've known practices not set on any ANPs though, and never had them, 'cause they don't understand it.*

The feeling that some ANPs were practising at a lower level, using the title erroneously, and "picking and choosing" the types of patients they were consulting with was a key issue for the participants. There was also a feeling that as the role develops, the wider management and commissioning directors are confused as to what the role is becoming and its limitations:

> *Laura: I'm not sure the commissioners and managers are really aware of the capability of the role and what we're really about. It's changing a lot and doing*

*more and more. They seem happy to play it out and see where it goes but I don't get the impression they are fully clued up on it.*

The idea that the key stakeholders in the role are not aware of the pace and depth of development in the ANP role is an important area of analysis and will be discussed further in the phase two findings.

This section has highlighted the broad findings of the changing role theme and provided an introduction to the categories of *variability, medicalisation* and *training*. The main areas of change are around the scope of practice and complexity of patients. As GP numbers reduce, it appears that ANPs are filling in the gaps in service provision. This requires ANPs to adopt a more medicalised role and take on new areas of practice. As the rate of change is different between not only individual GP surgeries, but also between differing CCGs, this inevitably leads to variability.

### 4.2.1 Variability

The variability of practice was a key finding within this study. ANPs reported that their practice was widely variable between differing areas. This was linked to the needs of individual surgeries, workforce changes, patient demands and personal development. Although variability is natural within a workforce, a key observation was that of underqualified nurses using the ANP title. This further led to perceived variability. Participants reported that they felt the defined role boundaries between ANPs and practice nurses could be confusing. One typical observation was that provided by Natalie, who observed how practice nurses and pharmacists were carrying out tasks previously performed by ANPs, and that the ANP role was becoming more specialised and blurring with that of doctors:

*Natalie: There's more and more practice nurses and pharmacists doing minor illness courses and advising patients on things like sore throats, coughs, earache and stuff like that. It's all good and I've no issue with it, but it means that ANPs are not seeing that type of stuff as much now, we're seeing more advanced and complex stuff with the GPs.*

The practice of general nurses dealing with increasing numbers of minor ailments, leaving ANPs to naturally deal with more complex patients was also identified by Angie, who described this issue:

*Angie: The practice nurses where I work are dealing with a lot more minor type things. This means that I'm dealing with more complex patients, naturally. It also means that they're coming to me for a lot more advice and prescriptions. When they see a sore throat and it's not all straight forward, they'll screen message me*

*to come to ask for advice. This used to be what ANPs did with GPs but it's now what's happening with practice nurses. It's rare the ANPs here go to GPs anymore for advice as we're used to dealing with everything.*

The previous response indicates a consequence of the role and workforce change within general practice. With multiple roles and areas of practice comes variability and confusion. Adelle indicated the misunderstanding this could cause for patients and receptionists, and the blurring of the boundary between the roles of doctor, practice nurse, and ANP:

*Adelle: It's confusing for reception and patients who to book in with. If a patient calls with a UTI [urinary tract infection] or a sore throat, they might get booked in with a minor illness practice nurse, and she then comes to me or a GP for a prescription. Some of these probably call themselves nurse practitioner as well.*

Although there is a distinction between the ANP and GP with the practice nurse when it comes to signing the prescription, taking responsibility, and being an autonomous practitioner, the practice nurse working at an advanced level and assessing minor conditions is possibly adding to the confusion around the ANP role and the variability of advanced practice, especially from an external viewpoint, such as from a GP or patient.

These ANPs echoed the findings of a large study by East et al. (2014) that found considerable variation in titles, educational preparation and working practices of ANPs across all UK health care, even within similar roles in the same settings. The present study differs from that research as East et al. did not explore how the variety of titles and working practices impacted the individual ANPs and their experiences of working in these conditions.

Participants saw variability as linked with experience and the make-up of the practice. An experienced, highly qualified ANP could blur the lines with a GP role more easily than an ANP who was newly qualified, inexperienced or using the title inappropriately. Although this appears self-evident at first, it creates confusion with employers and the ANP workforce. The issue of variability for the participants also related to titles and training:

*Adelle: There's a massive difference in ANPs and what they do in different areas. We should all be doing the same things and working at the same levels… Some are doing amazing jobs and roles… Some aren't for whatever reasons but they're in the minority obviously. I think it comes down to the training they've done. There's different courses in different areas and they're not all the same or at the same level.*

*Debbie: It comes down to the title. You shouldn't be able to use ANP if you're not and not done the masters'. I can't call myself a physio or a pharmacist can I, so why can a nurse say they're an ANP?*

The participants in this study were enmeshed in an international confusion about advanced nursing practice. A survey of 32 countries by Pulcini et al. (2010) identified 133 different titles related to advanced nursing practice, and a wide variety of practices and levels of competencies. A review of the similarities and differences of international regulation of ANP titles found title protection in Japan, New Zealand, Ireland, Singapore, Hong Kong, Australia and the USA, but not in the UK (Carney, 2016). This has led to variability of the practices undertaken by ANPs as a result of a lack of clear role definition and title protection, as Laura elaborated:

> *Laura: I've had a GP come to me and say, "If the practice nurse can see sore throats and coughs and ear problems, why do ANPs need three years' training and more money?" It's hard to argue with them sometimes about the titles and who can do what… It's hard for me to understand sometimes!*

With variability also comes variation in remuneration. As individual GP practices are autonomous businesses, they can decide to pay their nurses at a rate that is not determined by national NHS pay standards such as those set in Agenda for Change (DOH, 1999). The RCN (2012) recommends that an autonomous ANP should be paid at band 8a on the Agenda for Change pay band scales. Evidence exists that employers are not adhering to the guidelines, with pay varying from band 6 to band 8a (Marsden et al., 2013; Fawdon and Adams, 2013).

This was also an issue for the participants in this study:

> *Adelle: The problem is that we have to fight for our pay rate and demonstrate we can do it. We have to sit down with the manager or partners and say this is what I should be paid. They can just say no and that's the end of it.*

> *Diane: Everyone's paid a bit different depending on what you do and how many extended roles you have. Someone down the road working at a lower level could be on more money than me, and I do triage, visits, specialist clinics and loads of other stuff. I've heard some people say why should I do all that extra stuff, when they won't pay me for it and someone else is getting more?*

Although what the participants state is happening and what is happening in reality may be different, the important factor is that ANPs perceive there are differences in pay which are not dependent on actual work and responsibilities, but rather a lack of understanding of the scope of the role. Participants reported that variability was also influenced by organisational rules and practices. General practice is unique within the NHS, as individual surgeries are owned by the partnership and then subcontracted to the wider healthcare system, representing self-contained individual organisations. How the service is run and managed and care delivered is determined by the partners (GPs, managers or senior nurses) and delivered by the staff. This can lead to variability in

individual practice performance and roles. When a practice was experiencing acute pressures or personnel changes, such as during winter or high levels of holiday leave or sickness, ANPs could be asked to undertake additional roles to ensure service delivery:

> *Sue: When we're really busy 'cause of people being off or sickness, then I'm asked to do more, like stay late on my own or do some home visits or deal with more tests and results… that kind of thing. I sometimes wonder why we don't get a locum in, but the few ANPs here seem happy to do it.*
>
> *Lynda: The problem is staffing. When it's peak time or people off then ANPs take over more stuff. Then when it's quieter we sometimes carry on doing the new stuff, so it never ends. The more I do the more they let me do, if it's safe and it's working.*

The above quotes represent a pragmatic response to the pressures facing GP surgeries and expansion of the ANP role dependent on the needs of the organisation. There is a wide variety of types of GP surgeries with some taking on responsibility for a large number of care homes and elderly patients, and others having mostly younger patients and students i.e. those based in cities with numerous universities. This inevitably leads to a variation in the roles carried out by ANPs.

Definition of participants' role were influenced equally by organisational needs and individual choices or self-determination, although they were happy to abide by the surgery's influence on their development. The RCN (2019) four pillars of advanced practice describe leadership, autonomy, research and being an expert as key to performing at an advanced level. In certain areas where the ANP role is not understood or used widely, there is a risk that their role isn't meeting these criteria through no fault of their own:

> *Natalie: I'm aware of a couple of ANPs that I talk to at meetings and training where the GPs won't let them expand and do things, 'cause they're not up on what ANPs can do. It's frustrating for them 'cause they're watching others do a lot more. They're qualified and experienced but stuck doing minor illness type consultations, and other surgeries are moving their ANPs into all kinds of roles, so that can add to the mixed practices as well.*
>
> *Carly: I'd like to do more advanced type roles one day, maybe do a specialist paediatric course or something like that if that's what's needed. It's hard when the GPs don't really know what we're capable of doing.*

The participants in this study were all expanding their roles to meet the needs of the organisation. Where there are single ANPs in a small practice, it may be difficult to accomplish these changes if their employers and GPs are unfamiliar or not used to the role. This leads to further variability amongst the workforce.

ANP participants were overwhelmingly positive and eager to take on these extended roles where possible, and keen to discuss their ideas with management and the partnership. Commonly, ANPs expressed an idea for a new service or role for themselves, which was then trialled. When the employers were confident it was safe and effective, it became an ANP-led service. This was evident with family planning clinics, end-of-life care, triage and home visits:

> *Debbie: We had a team meeting about a year ago due to staffing changes… I said I'd be interested in doing some triage and visits kind of thing 'cause we were struggling. We worked out a rota, so I'd do a morning surgery and then have a gap to do phone calls and visits. It's worked out well, and the GPs love it 'cause it means less calls and visits for them.*

Laura described not only taking on a new role following training but also her experience of acting as the ANP lead for this specialist area:

> *Laura: I'm the lead for the end-of-life care for the surgery. I've a special interest in palliative care and I've done the palliative degree. Once I'd done that I had a meeting with the lead GP and manager, and I put my view forward for how it could be redesigned. It works really well now with continuity of care and a good quick response to problems.*

This section has highlighted the variable nature of ANP practice. Various influencing factors are discussed by the participants including organisational structures, the workforce dynamics, regulations, titles and individual ANP motivations for extending their roles. The ANPs demonstrated a willingness and in many cases, an eagerness to undertake a more medical type of role, training in new areas, and being encouraged by their employers. This process was seen to be largely organic and localised, without any national influence or specific policy. With these changes to their role and the undertaking of new practices, they felt the role was becoming more *medicalised*.

### 4.3.2 Medicalisation

All participants described their current practice as dealing with increased patient numbers, complexity and working at a very high level of technicality. They were all keen to describe how the types of patients they were now dealing with were different to several years ago. The current consultations with patients were very complex and required a perceived merging of the nursing and medical approaches, rather than a purely holistic nursing assessment. The title of 'advanced nurse' held significance for the participants, but an overarching issue was one of questioning whether the role was still entirely a nursing one, due to the pace of changes:

*Lynda: I'm not sure what we're doing now is totally nursing. It's not like we're on a ward doing the traditional nursing kind of things, we're a lot more medical now doing consultations… It's a lot more medical now than say five years ago.*

*Jane: I think we're still nurses… just. But it's becoming a lot more medical, I think. We have to now think like doctors, not like nurses.*

The current ANP working practice was seen by participants as more of a junior doctor type of role, but one they were comfortable and eager to undertake:

*Ann: God, I'm doing more now than I've ever done. It's a lot more complex and doctor-like stuff. I'm doing MRIs and getting the results to deal with and loads of bloods and interpreting everything. There's no other GPs to deal with it all so we're doing it now. The training doesn't teach you how to interpret an abdo MRI scan and let the patient know what's wrong and how you're gonna manage it. I think that comes with time and loads of experience. I like it though.*

Lindsay described the impact of the appearance of medicalisation on her self-identity:

*Lindsay: We have student nurses who come and spend time with the ANPs, and they say its brill what we're doing, but they say they're not really learning nursing things 'cause they say we're just like doctors. It makes you think when student nurses say that, and they're probably right in some ways.*

Jane appeared to agree, describing her feelings of the medicalisation of the ANP role:

*Jane: Yeah, people call me doctor or think I'm a GP all the time. Even on the phone to hospital doctors. I admitted a patient the other day and said I'm an ANP and went through all the history of the patient, what was wrong, obs, blood results and all that. At the end he said, "Okay, thank you doctor, send him to ward 22." Happens a lot. It does make you wonder sometimes about what we're doing and how far I've come from the ward nurse from years ago. That uniform and badge sets you aside from doctors, and here we're seen as all the same I think, except the money [laughing]. You can feel a bit miffed when you think about it.*

The above appears to reflect on the transition from nurse to medicalised role, abandoning the uniform and badge, in favour of the stethoscope and diagnostic instruments. The medicalised vocabulary naturally used by ANPs was seen to further add to their transition from a nursing role to one of a more medical nature. Although ANPs have always been independent practitioners, assessing, managing conditions, prescribing, ordering and interpreting test results, participants felt that the evolution of the role now demands a much more medical and analytical type of approach compared to several years ago. Lynda exemplified this sense of the complexity of the role:

*Lynda: I think our role is definitely changing. I think initially it may have been a little bit about, "Okay, we are a bit short of doctors, let's put some ANPs in and see what happens". But I think they are kind of looking at us now as all-rounders really, so we can do everything, and it seems to be working. The last few years have changed a lot for me and the other ANPs here. The types of patients I'm*

*seeing now is crazy compared with a few years ago, and I'm not sure how far it's going to go really. At this rate I'll be doing open heart surgery in a few years.*

Sue echoed Lynda's comment regarding the range of the tasks she now carries out:

*Sue: Because I know I'm not doing minor illnesses anymore like we used to, we are doing everything that comes through the door. From minor to major, to complex stuff, and continuity as well. Anything and everything get booked in now with me and my scope is a lot bigger than it used to be. I don't mind though, it keeps me going.*

Diane attempted to explain why this was happening, suggesting a general movement where each level in nursing (here specifically practice nurses and ANPs) was required to take on more complex roles:

*Diane: I also think we have now got other people in practice taking away some of the minor illness, like practice nurses, so therefore they take the minor illness and we are having to see the complex, and I think that's where it's changed, and I have felt that over the last few years, a big big change in my work, in the patients that I see and the work that I do.*

It was clear that ANPs do not think that practice nurses are stealing their roles, but rather that they are stepping in to fill the gap created as ANPs take on more medical tasks. There seemed to be a general feeling that all levels of nursing within general practice were developing and increasing their scope to accommodate reduced GP numbers and increased demand. Rachael's theory was that this was due to a shortage of GPs. There seemed to be a general feeling that the shortage of GPs was leading to ANPs having to take on a doctor role, meaning that practice nurses had to step up and take on many of the tasks previously carried out by ANPs:

*Rachael: The types of patients and problems I'm dealing with now has massively changed from even a few years ago, probably because there's not as many GPs. We're expected to just get on with it as there's no one else, but we do and 99% of the time the patient is sorted, happy, and it's just the same as if they'd seen a GP. There's absolutely no difference in what I see and what a GP sees here.*

The notion of the role changing over time, becoming more medicalised and stepping into the GP domain was a strong theme throughout all the interviews, as Sue described:

*Sue: It's mostly 'cause of GPs leaving or reducing hours. We have three ANPs here and we do visits, triage, clinics and do specialist stuff. We're becoming like doctors and doing a lot more complex stuff. But you know what, I think we're doing a really good job here, and patients love booking in with us.*

Jane and Debbie described the patient demand for ANP consultations:

*Jane: Our sessions are booked full every day and a lot of patients request us instead of a GP. We have regulars who will only see ANPs, they haven't seen a*

*GP in years.*

*Debbie: We definitely have our regulars and also patients that want to see an ANP 'cause they think they get listened to more. We have a bit longer consultation, so they come with a list. I've never had one patient walk in and refuse to see me, they all just want to be seen and dealt with, doesn't matter who it is, and go out from me sorted hopefully, just like with a GP.*

Joanne not only highlighted the demand for ANP appointments instead of GPs but also described the impact this had on her:

*Joanne: When patients only want to see an ANP, sometimes only a particular ANP, and they wait weeks to book in with you, it does add more responsibility and make you think how much you're kind of responsible for them. They won't see a GP and so everything's on you really. Ideally, patients should see different people to get a different view on their problem or ongoing things. ANPs sometimes act as their named person and deal with everything. That's like being their sole practitioner and stepping into the GP role.*

The notions of ANP medicalisation and the blurring of boundaries described by the participants are supported by the findings of Nadaf (2018) and Hall (2016), who each reported that ANPs in emergency and primary care were extending into the medical domain in everyday practice and dealing with more complex conditions. Not only were the types of patients they cared for changing over time, but the responsibilities and specialties of the role were also seen to be changing. The practice of ANPs increasingly stepping into the medical domain has also been noted by the medical profession. The BMA has commented on this transition and expressed veiled concerns for patient care (Laurant, 2018) around safety and who has overall responsibility. The general media has also recognised these changes, with the British Broadcasting Corporation (BBC) asking, "Are nurses the new doctors?" (Triggle, 2018). A large mixed-methods study by Lovink et al. (2019), substituting ANPs for doctors in primary care, found that, with collaboration between the professional groups, ANPs could effectively replace the routine assessments that doctors were carrying out and respond to acute requests safely.

The present study provides insights into not only the types of roles being undertaken, but how ANPs are experiencing the expansion of their roles. The participants were keen to express their view of the medicalisation of the ANP. It was not always one of hesitation or uneasiness about adopting a new role, but one of necessity:

*Lynda: So that we can effectively carry out the job and do more GP type stuff, we have to become more medical with the consultations, visits, phone calls. The 10- or 15-minute appointments mean we can't do all the nursing type assessments and do a social assessment and other stuff. We need to be more medical and treat one thing at a time.*

*Laura: ANPs are now dealing with a lot more, so we have to become more like a GP. Our prescribing and audits all are the same and seen the same way. No matter how much the patients like you 'cause you're a nurse, we still get judged the same way as a GP… When I'm out doing visits or triage, I work in the same way as a GP doing the same things. There's no difference in our work anymore, I get all the same test results and scans and x-rays to sort out… But I love it.*

The sense of leaving their nursing profession behind, hinted at by Lynda, was expanded upon by Rachael, who described the feeling of referring tasks she previously carried out to other nurses:

*Rachael: All the time I refer patients to other nurses like practice nurses and district nurses to do dressings or assessments… bloods, pressure care, end-of-life assessments and that kind of thing. I sometimes think well I'm a nurse and I can do that, but it's not my job anymore 'cause I'm more of a medical type person now, and I have to refer to a nurse to do that… Weird sometimes.*

The idea of medicalisation was not purely about taking on tasks previously carried out by a GP. Participants described the need to consult with patients in a 'medical' manner to work at an advanced level. They described the university training, extended role courses and updates on prescribing all being carried out in a more medicalised way rather than with a nursing approach:

*Diane: When I did my training, it was all about the nursing element and side of things, like communication, putting yourself in their shoes and nutrition and obs and all that. Now when I go on updates and training it's all medical stuff, prescribing, guidelines, pathways and all that. You have to do consultations with that way of thinking now, rather than a nurse kind of way.*

Adelle built on this narrative by describing her mental approach to consultations:

*Adelle: I just walk, talk and act like a doctor, I think. The nursing bit is there, and it helps me, but in modern GP surgeries, everything is about targets, pathways and not getting sued. If you want to work now as an ANP you have to approach it in a medical way I think. It takes newly qualified ANPs a while to get into this way of thinking. You can see them changing over time when they first start.*

This again highlights how ANPs feeling that they are not only taking on new medical-type tasks, but their demeanour is changing as they adopt the behaviours and roles of the medical profession. This is emphasised by the fact that most ANPs saw their consultation styles, format, timing, and types of patients as identical to those of a GP. Patients were not interviewed for this study, but there is evidence of how this change in demeanour of ANPs is regarded by patients. Horrocks et al. (2002) and Richards and Tawfik (2000) found that patients viewed the consultations with ANPs to be better communicated than with a GP, and the medical care on a par with their GP colleagues. The ANPs in the present study thought that their patients felt the same way, i.e. that

their communication was more effective than that of a GP. ANPs gave possible reasons for this:

> *Laura: I don't think the doctors get much training on communication and listening like nurses do. It might be changing now though and the medical students we've got are really good. The older GPs who trained years ago sometimes struggle. I see patients who come to me with the same problems they saw a GP for a couple of weeks before and they say, "I've come to you 'cause you'll listen and explain it better."*

Quantifying the exact nature of medicalisation and their communication style change was difficult for the participants, but the following descriptions capture their thoughts as, interestingly, they observe the changes in training that doctors receive (more focus on communication) and those nurses receive (more focus on medicine)

> *Ann: I'm working as a junior doctor now, I don't care what the nurse leads say or what they're teaching in universities, we're all now working as medics, doing the same things as a junior GP. It's hard to say how or why we ended up like this, but it's our own doing and I'm happy to carry on what I'm doing… The patients are happy and safe. The only good thing I think is I can talk to them better, and the patients relate to me more than a GP they say. I still talk about medical stuff though, like investigations, results, medication, rather than nursey things.*

> *Rachael: I've had three ANP trainees all in university doing the ACP course… I never know what to call us these days, ANP or ACP… They've all been told to forget they're a nurse now and concentrate on the ACP model and the medical aspects of the job. I don't think that's right, but I can understand it… It's more of a medical model now. What nurses have though is the communicating with patients and relating to them.*

Participants' strongly held view that the role is transitioning to a medical model is contrary to the established thinking that the role still offers a nursing approach to patient care (Oliver, 2017). The notion that nurses take more time to listen to patients and negotiate their care management rather than simply prescribe a treatment (Paniagua, 2010) appears to be at odds with these participants' experience of the role and how it is developing. This is exemplified by Jane's description of role transition:

> *Jane: We're changing definitely. I have 10- or 15-minute consultations. There's no way I can act like a nurse and do all the nursing communication things, listening, management plans, joined up me-and-the-patient type approach to care and all that. I have to act and talk like a GP to get them in and out, not in a bad way though. You have to get through it quick, move the consultation on and then onto the next. It's not good sometimes, but with the types of patients we're seeing now, you can't get drawn into the nursing side of things or you wouldn't be effective.*

This section has analysed the theme of the medicalisation of the ANP role. In order to undertake more medical-type roles in general practice, ANPs were retraining in specific areas. Diane's observation on this will take the discussion to the next section that

focuses on further training as an element of role change:

> *Diane: We have to train on new things all the time to expand. We have ANPs doing specialist things, still seeing all types of patients but taking a lead on areas and doing specialist roles for courses they've been on.*

### 4.2.3 Training

The requirement to specialise and undergo further training beyond the ANP qualification was a common finding in the data. With GPs leaving or retiring who had a specialist interest in a certain area such as diabetes or cardiac disease, ANPs were being asked to undertake further training in these areas:

> *Natalie: You can never stop training. We're always being asked to do some updates or courses. We had a GP retire who did all the diabetes management with a nurse, so I was asked to take this over and kind of lead on it. I'm halfway through the training now and enjoying it, I don't mind but it's something else I have to deal with.*

Her observation, alongside that of Carly that follows, illuminates the piecemeal way in which the ANP role is developing; they step up to fill specific gaps, rather than as part of planned development of the role:

> *Carly: Yes, I'm doing more training. I'm starting a women's health diploma next month 'cause one of our female GPs left, and we're struggling a bit for smears and coils and that kind of stuff. A practice nurse could do it, but as an ANP I can lead on it and do some training to do implants and fit coils.*

Formal training was not always required to adopt a new role. Informal in-house training and support were required where a set qualification was not available. This was the case with home visits, triage and acute appointment requests, which were areas taken over by ANPs:

> *Adelle: We have two ANPs who do all the home visits every day. We both went on a couple of days training on acute assessments, triage and 'spotting the seriously ill patient' kind of thing. It wasn't a set course and we knew a lot of it already, but it was good as a recap and the GPs felt better that we were starting a new role and we'd done an update course.*

Lindsay described the support offered to ANPs by GPs when they started a new role previously undertaken by doctors:

> *Lindsay: I do triage and home visits since about a year ago. We needed to rethink the way we do things and other areas have ANPs doing visits, so we started. We get monthly updates with the GPs and they're on hand all day if I need anything or advice. I sometimes ring one of them from a patient's house and they're good like that to help me. It's not often I have to though, I deal with*

*most things.*

The participants were keen to branch into new areas as long as they were supported and rewarded, as described in the previous comments. In most cases, support, training and financial reward were provided for ANPs willing to take on new aspects of care. Several ANPs had recently spent time with GPs doing home visits and triage to gain experience in these areas, as in the case with Lindsay. They had then taken on this role regularly and felt confident and supported by the GPs and management. No participants felt strongly unsupported in new training, roles or responsibilities:

> *Natalie: I feel very supported and looked after. I don't need constant supervision or monitoring but the GPs are here if needed. I wouldn't do what I'm doing if I felt I was out on my own and vulnerable. You can only do what you're trained in and what you're safe with.*

The initial ANP training was felt to have adequately prepared them for the role, but they also believed that substantial consolidation and experience was needed to carry out the role effectively. This was seen to be dependent on the organisation and levels of support for the ANP. Laura described the process, from initial qualification to developing a level of confidence and autonomous practice:

> *Laura: If you qualify and work in a really good practice who support you and let you expand then you can do loads of extended roles and really fly.*

Although all participants had a minimum of three years' experience as an ANP, training practices appeared to be better equipped to deal with newly qualified ANPs than smaller non-training surgeries.

> *Laura: Some ANPs qualify and work on their own in a small practice with no other ANPs. They seem to get stuck in the minor illness type role. Maybe 'cause the GPs or managers don't know any different.*

This was expanded upon by Diane and Carly, who spoke about the differences in support and role development:

> *Diane: [Training practice] We're a big practice and have loads of ANPs and ACPs. We're a super practice so we have about 40,000 patients and the branches are all over. We're training as well, so there's a lot of students coming and going. We have a lot of training and support. If there's something we want to do they're usually okay with it and keen to push us to do things. All the ANPs here do specialist roles and take a lead on things. I do end-of-life care and the others do women's health, anticoagulation, diabetes and that kind of thing.*
>
> *Carly: [Small non-training practice] We have two ANPs here and three GPs. We're only a small practice so there's not much need to do extra training and branch out. We're seeing complex patients and sometimes do the odd home visit but mostly its clinics… acute and chronic patients. We do train on things and keep up to date, but we've not specialised in anything specifically. We're*

*supported though and happy.*

As in the above examples, it may be the case that in larger training practices with greater numbers of ANPs and allied professions working together ANPs are able to extend their role into new areas more readily. In their study of primary care ANP-led services, Parker et al. (2012) recommended that ANPs have access to supervision and ongoing education by their GP colleagues; this appeared to be happening on the whole in the present study. As all ANPs in this study were fully qualified, they did not require formal training or supervision from GPs, but they had informal updates and training as a practice involving all clinical staff. It may be the practice that larger practices with multiple ANPs are more able to adapt and evolve their workforce to meet the needs of patients, and smaller practices with one or two ANPs are not able to do this as effectively. All participants stated that they felt supported, underwent regular training and updates, and were able to seek the advice of a GP whenever it was needed:

> *Adelle: I definitely feel supported and I can go see a GP about a patient without any issues. We get regular updates on things all the time. We have to work within the scope, and we don't do anything we're not sure of.*

Several participants were going through the process of specialising in a particular area away from a generalist ANP. This involved master's-level training, including palliative care and musculoskeletal qualifications. Their employers were satisfied that the ANPs could undertake specialist roles and it was within their scope of practice:

> *Ann: So at the minute I'm doing a palliative care degree. I act as lead for end-of-life care for the practice at the moment, but I'd like to focus on this area in time and be like a specialist for the three sites. It's a bit hit and miss at the minute, the end-of-life care, and not a lot of continuity. I think having someone who's trained and doing it as a specialist role would be good. The GPs like the idea as well.*
>
> *Jane: I'm doing a musculoskeletal course now. It's so I can specialise in this kind of thing and see more of the back pains, knees, hips. There's no one here who does that kind of thing with a special interest and I like that area. It's hard but I'm really enjoying it.*
>
> *Joanne: I'm starting a minor surgery course next month. One of the GPs who's getting close to retirement does this now and I expressed an interest in taking over and we looked into it. There's no reason ANPs can't do it and the indemnity covers me okay.*

Once the training was complete, the plan was for the ANPs to lead and specialise in these areas as autonomous practitioners. Duties included palliative medication prescribing and advice, responsibility for all aspects of end-of-life care without a GP, undertaking specialist clinics and minor surgical procedures. The practices where these ANPs were employed tended to be larger, multi-site training practices with multiple

advanced practitioners including paramedics and pharmacists working in multidisciplinary teams:

> *Diane: We're a big practice, yeah. We have a lot of students and we're always on some kind of course. We like it though, it stops us getting bored and just seeing basic stuff. We've got paramedics doing home visits, pharmacists doing medication reviews and changing meds, and the ANPs do the rest.*

As Diane described, undertaking additional training was not seen as a burden, and participants did not perceive that they were being forced into a new area of practice. All were eager to develop further:

> *Rachael: No, I'm not pressured into doing courses or new roles. We're all keen here to move on. As long as the salaries are reviewed to reflect the new roles we're doing, then we like taking on new things, and our salaries here are good and reviewed every year.*

Lindsay reiterated this belief that no pressure was applied to take on a new role with the need to undertake more training:

> *Lindsay: I'm never forced into doing anything. There is demand and we all do more and more complex things, but we're keen to progress and learn new areas. We go to training events and keep up to date, you have to. There's always one of us doing a special course on something. It's like if one of us is doing something, the others are like, "What's she doing, I think I'll do a course as well."*

All participants had yearly appraisals, where their training needs were discussed and adopted, where appropriate, after being agreed with the partnership. In three cases, ANPs had expressed an interest in developing a new skill or role that was rejected by the GPs. This did not appear to deter them:

> *Jane: A while ago I had my appraisal and wanted to do a heart failure type diploma. The GPs said it was interesting but wanted me to carry on my current role. I think it might have been 'cause they were worried I might start doing more chronic heart failure type clinics, and not all the home visits and phone call triaging for them [laughing]. I'm happy doing what I'm doing though, and maybe do something else in time, some other training.*

> *Mandy: I was thinking about doing a diabetes course but when I spoke with them [GPs] they said there was no need at the minute. It's ok though, I'm happy doing the ANP role. It's not a do or die thing, but you do feel like you need to do some new training all the time.*

> *Lynda: The GPs never seem to do new courses or training, so when we ask to go on a diploma or course, they're a bit confused I think. It's kind of bred into nurses to always be training and doing courses. I wanted to do an asthma diploma as well as being an ANP, and the GPs were like, "What for, you're looking after asthma patients now."*

This section has analysed the theme ‘changing role’ which incorporates the subcategories of medicalisation, evolving role, and training. The three categories were related to how the role is evolving due to the needs of patients, the organisation and the workforce. Recurring issues were found in all the categories, including issues around the need to fill the gaps in service provision, doing more with less resources and the role taking on more of a medical identity. The recurrence and frequency of these interconnected topics testifies to their significance and relevance to the ANP participants. The evolving nature of the role was directly linked with a need to undergo further training in specific areas. This expansion and the lack of GPs was leading to a more medicalised role, with ANPs adopting many of the roles previous undertaken by GPs and being routinely mistaken for doctors, by patients, and interestingly, by other nurses and doctors. ANPs were conscious that their demeanour, working practices and interactions with patients were taking on a medicalised nature as the patient consultations were becoming more complex over time. These changes were once again, an organic process, dependent on local influences, without a clear policy or strategy.

## 4.3 Theme 2 – National Strategy

Internationally, ANP roles have developed on an ad-hoc basis, in response to local and national healthcare demands (Bryant-Lukosius et al., 2004). There are significant differences in each country’s legislative and regulatory approaches (Kooienga and Carryer, 2015). Within the UK, all nursing is regulated by the NMC who hold a register of qualified nurses, although no distinction is made between newly qualified, specialist or advanced practice nurses. There are also no title protections or scope of practice regulations for advanced nurses. In theory, there are no limitations for a nurse who has undergone extra training in a particular area and whose job description allows him/her to undertake a particular role (Freund et al., 2015). The lack of regulation and strategy for advanced practice has led to a mixed and confused picture of advanced practice, as seen in the discussion of variability above. The second major theme to emerge from the analysis of the interviews with ANPs was *national strategy*, with a sub theme of the *nursing voice*.

The ANP participants expressed concerns around a clear lack of both national and local strategies for dealing with advanced nurses, their scope, education, regulation and protection. The scope of practice of a practitioner describes the role to be undertaken, the knowledge required, the attitudes and skills essential to perform the role, and the

mechanisms of accountability (Schober 2007). The roles undertaken by ANPs typically involve tasks previously performed by the medical profession (Heale and Buckley, 2015) although the extent of this is decided locally within CCGs, GP practices and sometimes by individual ANPs, not at the national level. The combined local and national regulation of advanced practice is problematic for ANPs as the perceived lack of national guidance results in local confusion and the lack of a clear scope of practice. This was a common issue raised by the ANP participants and they firmly attributed this issue to national leadership and regulation.

Diane describes her thoughts on the national picture:

> *Diane: The problem is they've just let us get on with it for years and years and nurses have done an amazing job and now it's almost too hard to try and regulate it all. They've been saying for years that it needs sorting out but they can't. There's too many titles and people doing widely different roles to try and rein it all in. I don't think the problem though is with the highly qualified ones doing an amazing job, the problem is with the ones who aren't properly qualified using the title.*

Lindsay reiterates the thoughts of Diane and describes the historical pathway and route to advanced practice:

> *Lindsay: I see it as nurses just gradually started doing more and more medical type roles and then attended more courses. We took over as a cheap option and nurses are always keen to do more medical type roles as a status kind of thing. Then we invented new names and titles. Then everybody started using them. The fully qualified ANPs working autonomously and doing the proper job are almost in the same group as all the others. The national regulators and NMC and RCN have been asleep at the wheel and not wanted to interfere.*

Adelle highlights and links the problems of regulation and the unqualified nurses practicing at an advanced level:

> *Adelle: The problem is, and I've attended a lot of conferences and meetings about it, is when there's a proper national register of ANPs or ACPs with set criteria, what happens to all the nurses who don't quite meet the level? Are they demoted or stop getting the wage or have to retrain? I know a lot of ANPs who did the course when it first came out but not the full masters and they're in their 50's. They're not going back to Uni for anyone but they're really good ANPs and their GPs and managers wouldn't have anyone else*.

The issue of regulation was seen as a national problem, although the participants struggled with a strategy to remedy this, as evidenced in the following two quotes from Debbie and Lindsay:

> *Debbie: We all want the title to be sorted and only fully qualified nurses to use it and be recognised…but I can't see it happening and it'll be too difficult to sort it out. It's gone on too long now. Even the new ACP courses are saying use*

*whatever title you want to the students. They're not ACPs cause that's not a title they say, just a level. It's really confusing, and I don't think it'll be sorted for ages, if ever. There doesn't seem to be any leader saying this is what it actually is and how it's going to be.*

*Lindsay: They added the nursing associates to the register within a year, but they can't sort the ANP register out. I think they know that it would knock the whole nursing levels out of whack from hospitals to A&E, GP surgeries. Everyone would be scrambling around to see if they're ok or not, some would retire, some would have to demote, and others would be ok. It'll be good to sort it but I don't think it'll happen. No one at a national level is willing to take the plunge and do it.*

Natalie and Rachael offer a potential solution to the problem of national strategy:

*Natalie: What they should do is just start from now on with the scope and level and titles. Anyone still working will eventually phase out but new ones going to university should be told this is the title you have if you qualify. Hospitals and GPs shouldn't be able to employ anyone without the qualification and evidence….this wouldn't be doable probably though.*

*Rachael: We don't hear anything really from the NMC or RCN on the shop floor about what they're doing about it. One of the main frustrations of me, but I know others as well, is they seem not interested in protecting properly qualified ANPs. They'll happily investigate you and strike you off if you make a mistake, but they're not bothered if a nurse is calling themselves an ANP without doing the full course. They should put a lot more resources into investigating this and striking off the nurses using all different titles when others have worked really hard to get to where they are. That will soon stop it.*

The RCN (2012) describe the four pillars of advanced practice as a *level* rather than a *scope* or *criteria.* They also assert that advanced practice should not be concerned with a title or role, and the scope may also include nurses working in research, education or leadership. This may be confusing as discussed previously, as without a title, scope or specific role, the notion of the *advanced nurse* is very broad and may lead to variability and an unclear strategy, as Jane asserts:

*Jane: The main issue is that you can say, you can define all you want what advanced nurses are or should be…but unless you say "this is your title, this is your qualification and this is your scope", everyone's confused, especially those employing us, and probably patients.*

Ann gives her thoughts on the RCN's four pillars of advanced practice:

*Ann: It's all good and it gets people talking but they say ANPs need to be involved in research and education. When we say we see patients all day long every day and that's our main role, they say well then teaching patients a about new inhaler counts as teaching…or looking up a guideline for something is research. That defeats the object. You can get around the four pillars if you like. They haven't mentioned the title or scope at all.*

The above response highlights the problem with the "one size fits all" approach to regulation and the perception that the RCN's strategy may run the risk of not relating to actual practice. Diane and Lindsay also discuss the RCN's approach with the four pillars of practice and link this with the RCN credentialing program:

> *Diane: The RCN have a job to do and they come out with recommendations and guide. They refuse to give GP employed nurses cover though cause' we have our own in the practice, but they'll still take the payments unless you cancel. They say advanced nurses need bits off all the pillars but how do they know, and the employers and GPs don't really have a clue. Then they say pay us £290 quid and we'll credential you to do your job. I've been doing it 5 years after my master's degree and I don't know why I need to spend that for a badge. It won't change anything for me.*

> *Lindsay: The RCN are kind of on the right lines, but someone really needs to grasp this and sort it. Coming out with the four pillars won't change anything cause the ones doing the role and who've got the right qualifications just carry on and the ones doing minor illness without the proper training aren't affected cause the GPs don't know any different. They came out with the credentialing scheme, but I don't know anyone that's done it. I don't have time to do all that and I've got better things to spend £300 quid on. What would it change for me?*

In addition to regulation, national and local nursing leadership was also a strong theme within the interviews. The participants felt a lack of leadership and direction for ANP practice both locally and nationally. Carly describes her thoughts on national leadership:

> *Carly: I'm sorry to say that I really don't think there's effective nursing leadership. We have lead nurses here and there like NHS England or RCN but on the shop floor we really don't know what they're doing. Look at the wages of nurses and the shortages on wards and district nurses and all the overtime. You can't tell me that's effective leadership.*

Lynda also describes her thoughts on national nursing leadership and links this with the ad-hoc development of advanced practice:

> *Lynda: I've heard about chief nurses and lead nurses in different organisations. They never seem to be involved in the big decisions though, it's always the BMA or medical organisations. That's why there's no direction. If nurses were held in the same status as doctors, we'd have had a clear strategy for training and working as ANPs. I think nurses have just adopted these roles because there's no national leadership. If there is it's not working as it should.*

When considering the response above, highlighting the lack of direction, strategy and regulation, it is worth considering the impact this may have on the utilisation of ANPs. A range of literature suggests unclear and disparate legislation and regulation of ANPs, in conjunction with a lack of strategy contributes to underutilisation of ANPs (Bryant-Lukosius et al., 2004); Lowe et al., 2012; Pulcini et al., 2010). These findings were at odds with this present study, where ANPs reported that they felt they were utilised very effectively and were increasingly moving into the domain of the medical profession.

Although this study didn't research ANP effectiveness, ANPs considered their role adaptable and successful in meeting patient demand and dealing with a reduction in GP numbers. If the current strategy for the ANP role is based on an out-of-date model, there may be an impact on healthcare provision if ANPs themselves, their colleagues and employers, and, as ANPs report, patients struggle to form a clear understanding of what ANPs can provide and their scope. This point is highlighted by Natalie:

> *Natalie: Without clear leadership and a strategy, everyone's confused about our exact scope, what we can and can't do. I've had GPs ask if I can do something and I say of course that's my main job, or patients say I didn't realise nurses could do that. I usually say well nurses usually can't do that but I'm an advanced practitioner who's done extra training to do this.*

The misrepresentation of the role highlighted above was argued by ANPs to be related to the issue of nursing leadership, which was deemed to be a problem locally as well as nationally. Within CCGs, nurses held positions within the organisations although the participants felt this was underutilised. Diane describes the situation in her CCG area:

> *Diane: We're a fairly big CCG and a lot of practices. Each one has ANPs and when we go to training events as a whole, the whole patch, there's no mention of ANPs or strategy or what we do. It'd all about the GPs, practices, targets. If there's a CCG meeting about something where representatives from the practices have to go, I've gone to some with the practice manager, we go around the room introducing ourselves and it's like "why is a nurse here, where's your GP". Actually, where's the CCG lead nurse and why aren't they representing us?*

Adelle also reflects on the issue of local nursing leadership:

> *Adelle: We have a lead nurse at our CCG. She just sends out loads of emails for training dates. She does that full time and doesn't see any patients at all. She's 100% CCG work. I've spoken with others about it and no one knows what else she does. She doesn't seem to be using her position to stick up for the ANPs in surgeries 'cause we're left out of most things.*

When asked about local leadership and the participants' views on their perceived lack of local representation, that is, why they didn't take the step into leadership themselves by forming a local group, arranging meetings, attending strategy meetings or becoming ANP representatives themselves, they had a clear answer, as highlighted in the following two quotes:

> *Sue: I'm not in this role to attend meetings all the time and sit round a table. I trained to see patients and treat them, that's what I want to do every day. I don't mind any nurse moving into management or CCG work but it's not for me. Someone has to do it, but if they do it, just actually act as a voice for nursing, don't just become another person who attends meetings.*

> *Natalie: I'm not into the whole let's have a meeting thing. The CCG would have us all just attend meetings all day if they could. Some people love endless meetings and strategy groups, nothing changes though…ever. I think the lead nurse thing in CCGs is just so they can say "here you go we've got a nurse representative" and tick a box. What they actually achieve, I don't know. I'd rather see patients.*

Although nurses do enter senior leadership positions, enter senior management and assume directorship positions, the ANPs in this study saw themselves as clinicians primarily. They reflected on their career path and at the point of considering a management route or senior clinical route, they chose to remain clinical and "hands on". The nature of this phase of the study, interviewing ANPs, naturally results in the participants all being clinical, assuming senior nursing positions, but having no senior management or senior leadership roles, out of their own choice. A large study of healthcare leaders by Khoury et al, (2011) found that although nurses are viewed as knowledgeable sources of health information, they are not viewed as leaders in the development of healthcare systems and strategy. The responses in this study also reflect this, although the ANPs wished for a different reality, as voiced by Mandy:

> *Mandy: I think nurses in boardrooms and CCG meetings don't really hold the same level as the GPs and commissioners and directors. They're there to tick a box. I wish it was different though and we had strong, kind of, representation. It's the same at the national level as well probably. It should be different though, we're the largest workforce in the NHS with probably one of the quietest voices and we don't stand up for ourselves.*

Joanne also reflects on the idea that nurses, according to her, are not viewed as leaders in the same sense as doctors, scientists and other professions appear to be:

> *Joanne: We can't be held at the same level and recognition as a doctor or specialist otherwise we wouldn't be in this position with so many strategies and titles. The GMC or Royal College of GPs wouldn't stand for this confusion.*

Joanne highlights the confusion with various national strategies for advanced nursing. The HEE (2017) framework for advanced practice represents a recent move towards a national strategy and framework for existing and training ANPs. Although it has yet to be fully implemented, the participants discussed the framework's approach, although most were confused as to its exact purpose and they were unaware of any specific details regarding it:

> *Rachael: To be honest I don't know much about it. Is it like the RCN thing?...It might be a set of guidelines for ANPs or set out how the training should be done. The thing is though, unless it's set in stone and all ANPs have to abide by it to get employed, it's not really going to be effective.*

*Debbie: Sorry I don't know about that. No one here's mentioned it and we have quite a few ANPs and ACPs. Some haven't been qualified long so you'd think they'd be up on all the recent policies.*

*Diane: They discussed that at a recent ANP forum event I went to. It said we'd all be working to the guidelines, even paramedics and pharmacists as ACPs. Sounds complicated. I hope it moves us on from where we are now though.*

The participants were also confused regarding how the HEE framework fits with the RCN credentialing scheme as Natalie and Adelle queried:

*Natalie: Does this replace the RCN credentialing thing? They'll probably have us paying twice for both of them. If it's voluntary like the RCN one, then it'll be pointless. Then again, if they're the same levels using the same kind of criteria, it's just duplicating it. I hope this one [HEE] is free though and we can align ourselves to it without having to pay money out.*

*Adelle: I thought the RCN had done something like that? If I'd just paid the RCN £300 and then this comes out for free, I wouldn't be too happy.*

There appeared to be apprehension and uneasiness when discussing the framework and how it may be implemented, the timescales and whether there would be financial implications for a national framework of advanced practice. Lindsay demonstrates the common feelings amongst the participants:

*Lindsay: How are they meant to test every ANP in the country to see if they're ok? That's going to cost a lot and I bet they start asking for money. It sounds like it'll take years to do that. I'm not sure what other choices there is though, to make sure everyone's working to a specific level. I worry about the old school ANPs who did the normal degree or post grad diploma and who're doing perfectly fine and the patients and GPs are happy with them. Are they going to be made to retrain or will they have to move down to a practice nurse? It's a bit scary and it's through no fault of their own.*

Lynda relates the lack of her understanding about the framework to the issue of national strategy:

*Lynda: It just sums things up really. Someone somewhere says we've now all got to work to this level, and we've all got to have a full master's degree and do some kind of research and teaching. For me it just sums up the lack of strategy overall and how nurses are making it harder for themselves. That's the thing with nurses, we love to hold each other back rather than pushing forward. For years they've turned a blind eye and let ANPs do whatever we want in a way. Now we've all got to do the same.*

The issue of a new strategy for advanced practice being introduced and many ANPs not being aware of it is also highlighted by Carly, as well as the nursing voice seemingly being lost:

*Carly: Sometimes when you think about it, we're the biggest workforce and it can only happen to nurses that there's a new strategy and policy for ANPs and*

*no one knows about it. You think, is that our fault or is it about decisions being made without us, or at least without the normal workers being involved. You feel like we don't have a voice sometimes.*

This section has focussed on the national strategy for advanced practice and the introduction of the HEE framework (2017) and the RCN credentialing scheme. The ANPs were, interestingly, not fully aware of the HEE framework and were concerned how this would be implemented, what effect it would have on their roles, and how the ANP title may be affected. They were critical of the national nursing leadership for this confusion and the perceived lack of a cohesive strategy between the various key stakeholders. They were also very critical of the lack of representation in national decision-making forums, especially around the GP contract discussions. They felt that this lack of a joined-up approach was leading to the *nursing voice* being lost.

### 4.3.1 The Nursing Voice

As discussed in section 2.9, the 2019 GP contract sets out a multi-year strategy for introducing advanced practitioners from a range of professions into general practice. These include pharmacists, physiotherapists and paramedics. The contract provides 70% funding for these posts when they're employed at a network level, a network being a group of GP surgeries with a combined population of 30,000-50,000, working to improve the care and service provision for this population, although still working as separate organisations. Although the 2019 contract emphasises the role advanced practitioners can play in general practice, it distinctly appears to omit the role of the ANP, instead only referring to advanced practitioners as ACPs, and only listing the roles of pharmacists, physiotherapists and paramedics in the funded advanced roles, not nurses. This factor was a key discussion point for the participants as Rachael elaborates:

*Rachael: I've spoken to others and we feel really let down about how other roles are being pushed and funded for the new networks and ANPs don't get a look in. Same old story. Why wasn't any nursing leaders pushing for ANPs to be recognised when this contract was being discussed?*

Adelle links the omission of the established ANP role to the lack of leadership:

*Adelle: The problem is we've not got anyone really fighting our corner. Surely when the new GP contract was being discussed the nursing representatives were asked about it? Was there really no one at national level saying "hang on, the ANPs and the practice nurses and the community nurses play a large part in this". It looks to nurses as if they sat on their hands and said nothing.*

Lynda and Mandy describe the feeling of being *"betrayed"* by the new contract and a sense of being taken for granted:

> *Lynda: I for one feel betrayed by the leadership. Imagine if that was the BMA or GMC. They wouldn't be left out of a new contract the way we have. I'm not sour or upset and I'm getting on with my job but it's a real missed opportunity.*
>
> *Mandy: It really says to practice nurses and ANPs that we're taken for granted and forgot about. It's like "whoa look there's new advanced roles for physios and pharmacists, they look good and could make up for the shortages", whilst all the time the ANPs and nurses have been there working away.*

Throughout the interviews, when discussions turned to the direction of travel and the GP contract, the sense of abandonment, being overlooked and having no voice was palpable as Laura also highlights:

> *Laura: It's like…how come there's new funding for the unproven advanced roles whilst ANPs aren't mentioned? I've nothing against the other ACP roles and everyone has their part to play but we've been here for years learning, training and proving ourselves all the time….Feels like we've just been abandoned and forgot about.*

The participants also described a feeling of ANPs being used to fill the gaps in service provision. Being used to replace GPs or *"move into an area we've not done before just because that area is short"*, although it gave the ANPs a sense of professional motivation, left them feeling used as a stop gap. Joanne and Lindsay describe this sensation:

> *Joanne: I love what I do and I'm always happy to take on new tasks and training and that kind of thing. But we're definitely used to fill the gaps and we're pushed into areas where the gaps are. First, it's a lack of GPs so we do home visits and other stuff, now there's an ANP afternoon urgent visiting service in this area for GPs to access, and there's the urgent walk in centre in our area that's totally staffed by ANPs.*
>
> *Lindsay: When we get told about the new contract and these other roles coming in that are also funded, we feel like we're forgotten about. Will these new roles be used to fill all the gaps like we are, or will they be protected and only do normal appointments all the time with supervision?*

The feeling of being a number and not a professional clinician was felt wider than general practice, with ANPs also being used in the primary care setting to *"fill the gaps"* as Sue describes:

> *Sue: The CCG here have just set up a care home and urgent visiting service that's totally staffed by ANPs. There's no GPs doing it at all. The practice can ring this number and ANPs go out to all care homes and urgent visits. The thing is though, ANPs take on these new roles 'cause we want to do them and we feel pride and able to use our skills. It is just a feeling of being shoved into gaps though to make the numbers up.*

The phrase *"used as cheap labour"* was repeated several times by the participants when describing the evolution of their role. There was a sense that commissioners and workforce strategists were required to find the most efficient and low-cost option for providing a service and ANPs "fit the bill":

> *Ann: I think when ANPs first started it was a distinct role and there was a place for advanced nurses in the team. Now it's getting more and more medical so we're taking over a lot of areas. My husband is a police officer and he saw the same thing with those community support officers taking over what the police were doing. Now we've got ANPs doing doctors jobs as cheap labour.*
>
> *Jane: It's like the move downward isn't it. Everything eventually moves down, so the lower levels end up doing a lot more and the top most senior people either do less and less or there's none of them about. It's just doing it on the cheap isn't it?*

The notion that the GP contract overlooked ANPs, an established GP surgery role, was a key finding in this study. This was felt to be a result of nurses not "having a seat at the table" and a lack of representation, as the following responses indicates:

> *Laura: The main issue is nurses don't have a seat at the table when these decisions are being made. When this contract was being drawn up, I bet there wasn't a nurse there saying, "don't forget about the ANPs who've been doing this for years".*
>
> *Joanne: We're not represented at all I don't think when the big decisions are happening. There might be a nurse on different boards and meetings here and there but when it comes to spending the money, I don't think nurses are involved.*
>
> *Adelle: I've been doing this for years now and ANPs are never represented when it comes to the big decisions and this contract proves it. Totally forgotten about.*

This section highlights the strong view that the nursing voice is being lost. They had a sense of underrepresentation in the national debate on healthcare and strategy. There was also a sense that ANPs felt overlooked in local service design and didn't have "a seat at the table". Although the participants were keen to expand their role, take on new duties and tasks, there was also a sense of being taken for granted and "used as cheap labour". As the role becomes more medical and widens its scope, there was also a sense of confusion around their professional identity, as discussed next.

## 4.4 Theme 3 – Role identity

Jenkins (2008) writes that the concept of professional identity includes an individual's experiences and feelings of oneself, for example, a person's experience of being a

nurse (self-concept), and others' image of that person as a nurse (social image). Professional identity is also formed as a component of a person's overall identity relative to their position in society, their relations with others, and the interpretations of their experiences (Fagermoen, 1997). ANPs bridge the divide between the nursing and medical domains, working alongside both nurses and doctors and undergoing a transition from care giver, to care prescriber. Johnson et al. (2012) assert that nurses' professional identity and status is often a subject in nurses' literature, but in contrast, little evidence exists regarding the formation of the ANPs' professional identity. The transition from a nurse's uniform to plain clothing, the use of medical equipment, the issuing of prescriptions, and the patient perception of an ANP being a *medical clinician* may be changing the self-identification that ANPs experience during this transition. The medicalisation of the role, as discussed in section 4.3.2, was found to be a key issue for the participants, but this also has implications for how the ANPs identify themselves and how other professionals and patients view the role:

> *Sue: Well I see myself as a nurse. But as we do more and more and we're able to deal with more and more complex things, patients just see us as a consultation and a way of getting their problem treated. It's the same with reception booking patients in, they don't see a difference between me and a GP when then phones are ringing off the hook. I go home sometimes thinking "well that was a day working as a GP".*

> *Adelle: Patients don't see much of a difference, I think. I introduce myself as an ANP and they go out of the room saying, "thank you doctor". When I go to care homes the carers introduce me as a doctor and the relatives say, "thanks doctor". We don't wear badges here but even if we did, I think they just see a person with a stethoscope who writes prescriptions and they think "doctor".*

It is interesting to consider ANPs' perceptions of how they appear to the general public currently, compared to how they think the public perceived nurses 20-30 years ago. Adelle, as noted above, describes patients not seeing a difference between ANP consultations and GP consultations. This may be due to the lack of a uniform for ANPs, a medicalised manner and demeanour, or public confusion concerning the role. The concept of role confusion and identity were also described by Jane, highlighting the impact this has on patients:

> *Jane: Patients get confused as well. They ring for a GP home visit and they get an ANP visiting them as that's how things work. They can't all have a GP visit and it's triaged. Sometimes the relative rings up later and says how come a nurse visited and not a GP. They're confused as to who's who and what ANPs can do. It's demoralising when they complain that they want a GP home visit for something that can easily be managed by an ANP, but they don't want a nurse turning up. Then there's the other housebound patients who love the ANPs visiting and won't have a GP. In one way we're scared about becoming doctors, but on the other we're offended when they want a GP and not an ANP. Here we*

*have practice nurses, ANPs, ACPs, a prescribing pharmacist and a minor illness nurse. There's no wonder patients are confused and just call everyone doctor.*

The above response highlights the ANPs' perceptions of how the public misidentifies ANPs as doctors. The ANP reports that the relative wasn't concerned that the ANP had visited and the patient had been mis-diagnosed or inadequately managed, but rather that there had been a miscommunication at the surgery. The overwhelming majority of patients were, according to ANPs, happy with ANPs visiting and many requested them instead of a GP. In other words, ANPs' self-perception is of themselves in a role that is sometimes paradoxical, but that generally is regarded positively by patients.

When undertaking previous doctor-only tasks, the ANPs were often experiencing *role confusion* themselves. Not only being mistaken for a GP but being seen by other nurses as something *other* than a nurse. The issue of role transition from nurse to ANP is also related to the perceived *medicalisation* of the role and was a key area of discussion for the participants, testifying to the importance they placed on it; a concept traversing several themes. This transition is discussed by Rachael and Lindsay, highlighting their struggles and mental processes required adopting a *medicalised* type role:

*Rachael: You can see it in newly qualified ANPs, and I was like it at first, where you have to get out of the nursing frame of mind and start being more like a doctor. You have to let go of the feeling of wanting to treat everything at once and do loads of assessments and scores, like nurses do. It takes nurses about 12 months I think to get into the new way of thinking after they've trained.*

*Lindsay: You have to see yourself as a type of medical person who's assessing and treating someone on your own. It's awful and I still see myself as a nurse, but you have to get into the diagnosing and treating frame of mind. The weird part is referring to other nurses to do things that you used to do like bloods, dressings, assessments and that kind of thing. You can't do it all and you soon start to behave like a GP even though you're not. This probably means patients see you as a GP…so yeah that's where the confusion comes from. I think most ANPs don't realise it's happening to them.*

The above responses raise an intriguing question of what it is to look and behave like a GP that the ANPs refer to. They recognised their own behaviours changing and adopting the GP frame of mind, which was apparently in turn recognised by patients. The above experiences reflect a large study of newly qualified ANPs by Brown and Draye (2003), who found that rather than being seen to represent clinical nursing expertise, ANPs reported being told that they were "no longer being nurses" and experienced role confusion and anxiety around not being recognised as part of a particular profession. This appears to also be evident in this study, as how they are perceived by others was very important to these ANPs:

*Ann: I really want everyone to see me as a nurse. It's hard though, especially with the older patients. They just see everyone in the surgery as a doctor unless you have a nurses' uniform on. That's the other thing, nurses who then work as ANPs leave the uniform behind in most cases and I think that shows that you're no longer purely a nurse.*

*Natalie: Hanging up the uniform when I qualified as an ANP and started working was one of the hardest things. Changing from a community nurse doing nursing things to wearing my own clothes and sitting behind a desk was hard sometimes. I just wanted to put a sign on my door saying, "I'm still a nurse!"*

*Debbie: I tell them all I'm a nurse. Even when I call the hospital to admit someone or ring a secretary about a patient they say at the end "ok thank you doctor" even though I started the call saying I'm an ANP. It's the way you talk as an ANP when you've done the job a while that just says "doctor" and not "nurse".*

Being accepted by others as an advanced practitioner and an autonomous clinician was also a key finding with ANPs articulating their desire to be accepted as independent practitioners. Professional status, acceptance of their skills, and recognition were seen as of paramount importance for the ANPs, even if this recognition conflicted with their nurse status:

*Diane: I want to be known as a nurse, but I also want to be recognised for the skills I've got and the level of training I've done. It sounds bad but I don't want to be lumped in with the generalist nurses…that sounds awful, but we are different and capable of a lot more. If we're still classing ourselves as nurses and nothing more, then we'll never be recognised for what we can do.*

*Adelle: We are nurses, but we're more as well. It's hard to describe isn't it. We're halfway between a nurse and a doctor. We've one foot in both sides and we're not willing to let the nursing bit go are we.*

Being accepted, however, wasn't always seen as an easy concept. The transition from general nurse to ANP was seen by some as a difficult transition to make:

*Lynda: If you train to be an ANP and then work as an ANP in the same area I think it's hard for the people around you to accept the change and accept what you can do. One minute you're doing a practice nurse role, the next minor illness and then complex ANP roles. It takes a long time for GPs and nurses to accept this change and trust you. It's different if you qualify and then start work in a new area 'cause they don't know you.*

*Laura: I did some more training in women's health to do all that kind of stuff, like swabs, smears, contraception and that whole area. I could do it all on my own, examinations and tests and treating different things. It took ages for reception and GPs and even other nurses to accept that I could do it on my own without a GP being involved.*

ANPs reported some professional rivalries between general nurses and ANPs, especially amongst ANPs and their practice nurse colleagues carrying out minor illness clinics, chronic disease management and specialist clinics:

*Debbie: The practice nurses sometimes think ANPs refuse to do things or we're all high and mighty now and we've left other nurses behind. We get that a lot. I have a friend who works as an ACP in a hospital and she gets a lot of hassle from other nurses about how she's abandoned her nurses. The nurses here are ok but there's the odd comment like "oh you saw this patient yesterday, but I've done the bloods for you today". You know they mean: "that task is beneath you now is it".*

*Mandy: Nurses are always mean to each other aren't they. They don't like it when someone moves on and gets higher. Most are ok but there's some who look at ANPs and specialist nurses like "who does she think she is does she think she's a doctor or what". I get that sometimes. I go into nursing homes on a home visit and the nurse there is like "I asked for a GP visit, but you can have a look at the patient if you like….*

Interestingly, this rivalry and acceptance didn't appear to be an issue between ANPs and their GP colleagues:

*Diane: I don't get any rivalry or issues between the ANPs and GPs about our role or boundaries or that kind of thing. I know there's sometimes a bit of that with other nurses but not with the GPs. They're happy to let us get on with it and do more and more…means less work for them [laughing].*

Acceptance as a nurse who has undertaken specialist training and who acts autonomously was seen as a "work in progress" with both their colleagues and the general public and the response by Natalie demonstrates the overall feeling of the participants:

*Natalie: I think ANPs are an unfinished role really. We're not there yet on where we're going. We've come a long way and we're doing a really good job what we're doing but the public and the powers that be don't really understand us yet or what we can do. They still see us as a nurse who can sort out a cold or a sore throat.*

The above response appears to be at odds with the ANPs' reports, above, of patients not seeing a difference between ANPs and GPs. It may however relate to nursing in general and not directly with ANPs, who are viewed by the participants as being a type of hybrid role. Due to increasing numbers of practice nurses undertaking minor illness courses, and who remain in a nurse's uniform, the general public may not see ANPs as traditional nurses due to the lack of a uniform and the medical equipment being used such as stethoscopes, prescription pads, and otoscopes. The response of the public "seeing a nurse as someone who can sort out a cold or a sore throat" may not relate to ANPs. This speculation is supported by Hoeve, Jansen and Roodbol (2013) who found that ANPs have a unique role and identity, and as ANPs' self-concept and social image are developing, their professional identity is evolving.

In summary, this section has explored how, with the advent of multi-professional advanced practitioners and the HEE (2017) framework, the ANPs were concerned that they may "lose the nursing element" of their role, becoming medicalised, and their behaviours changing. The transition from a general nurse to an ANP was seen as a difficult and stressful adaptation in the majority of cases. In addition to learning a new role, taking on a vast amount of new knowledge and treating patients as a clinician, becoming more medicalised and "leaving their nursing role behind" was a key finding. Although they considered themselves nurses, related to patients as a nurse, and using many nursing skills, they did not consider their role purely that of a nurse. Interestingly they also did not want to become a new clinical role, rather they wanted to "have a foot in both camps", which in turn added to the sense of confusion around their identity. There appears to be an ambiguity and duality to the responses of the ANPs. On the one hand they want to be recognised as separate to general nurses and enjoy their affinity with the medical profession, but they also want to retain their identity as a nurse. As the role advances, they were concerned that they were losing the nursing element as they took on more medicalised duties.

### 4.4.1 Losing the Nursing Element

The participants had an overall anxiety about being classed as generalist ACPs rather than advanced nurses. They described a sense of being pushed into a quasi-role of advanced practitioner that wasn't nursing, medical or any other profession and they believed the rebranding of advanced practitioner university training and the 2019 GP contract paves the way for this transition:

> *Lynda: It looks like they're inventing a new role of the ACP. It looks to be a generalist role and not really a single profession, just loads of different ones all called ACP. The training is now ACP and the ANP title is being phased out. It's a shame really. I think nurses really bring something extra to the role due to our background and training.*
>
> *Joanne: The new contract just says ACP, ACP, ACP…doesn't mention ANPs at all. The uni courses are all ACP now so in 5 or 10 years there won't be any ANPs left, just ACPs. Patients won't know who they're seeing. It'll just say ACP on the door. They won't know if you're a nurse, a paramedic or whoever.*

The nursing profession was seen as unique amongst healthcare professionals when adopting an advanced practitioner role, as the experience and generalist nature of nursing lends itself well to a more medicalised role, as Sue and Rachael describe:

*Sue: When nurses train we spend time in loads of different areas like paeds, psychiatry, adult, community, GP surgeries, A&E and get a lot of different experience. I think this lends itself a lot to moving into an advanced role. You could worry that the physician associates, pharmacists and paramedics doing it as ACPs haven't had all this experience with different areas.*

*Rachael: By the time nurses get to qualify as an ANP they've had a lot of experience. Usually years and years as a senior nurse. That's how it used to be anyway. Nurses spend a lot of time moving around in different areas getting a lot of experience in different conditions and assessments. This doesn't seem to happen with paramedics and pharmacists.*

Interestingly, ANPs who worked with other advanced practitioners who were not nurses, such as paramedics or pharmacists, had some minor reservations but were not as concerned as those ANPs who didn't work alongside other ACP professions, as shown in the response below:

*Lindsay: Here we have 3 ACPs who're nurses, a paramedic and two pharmacists, all ACPs. The paramedic is great for the home visits and the pharmacists do all the med reviews, thyroid meds and all that kind of thing. Sometimes patients don't know who I am, they say like "are you a nurse or a pharmacist" which gets to me sometimes 'cause I want them to know I'm a nurse. The ACP thing can get confusing but on the whole they're good here.*

The experience of the ANP and their route to advanced practice was seen to be important for them when undertaking an ANP role, in addition to the profession itself. Rachael represents the common feeling of the participants:

*Rachael: Nurses can become ANPs or ACPs wherever they work really. Nurses in A&E become ANPs…or ECPs I think they're called, nurses in GP surgeries become ANPs, and specialist nurses like in outpatients or clinics become specialists in their area. The worry is the generalist role of ACPs where no-one's a specialist and everyone does the same, no matter what their profession or background. It's not clear.*

Several participants expressed severe reservations regarding allied professions being able to adapt to a more generalist ACP role, although they admitted they didn't have much experience working alongside them:

*Ann: We've not had any ACPs working here like paramedics or that kind of role. They might be good for certain things, but we'll have to see if they can do all the wide range of patients that experienced ANPs see.*

*Diane: We have a ACP pharmacist working here but he only sees the medication related things, like changed to blood pressure meds or thyroid or anticoag meds. He doesn't really see anything and everything like the ANPs do. Maybe that's related to the experience and background.*

Professional groups are known to have differing moral and ethical philosophies of care. The paternalistic approach of the cure-oriented medic, versus the public health and social advocate stance of the health visitor are examples of this (Daly 2004). The ANPs

considered nurses to be multi-skilled as a result of their generalist training, wide scope of practice, and varied specialities available to them when qualifying. This was seen to lend itself ideally to ANP practice. The nursing *holistic assessment* was seen to also lend itself to the more medical model of assessment, diagnosis and treatment role of the ANP. They appeared concerned that a multi-profession role would *"lower the benchmark of advanced practice to accommodate other professions":*

> *Debbie: The problem for me is that nurses have excelled in these roles. Setting guidelines and making everybody the same as ACPs would probably mean that the role becomes static and can't adapt. We'll all just be doing the same thing at the same level…kind of a generalist.*
>
> *Lynda: It's like dumbing down really. It's saying, "right you're all advanced but let's call you all ACPs so no one knows where you're from" and then we all work to the same set of rules. Why be a nurse then? What's the difference?*

As previously demonstrated, the title and recognition as a nurse was important to all the participants, although they saw the ACP title and role as a move designed to amalgamate additional roles into the established ANP role:

> *Rachael: As there's a shortage of nurses and they need someone to fill the gaps with GPs, it just seems like it's a move to get the other professions into this role, even though they're not used to it and don't have decades of a proven track record. We've fought for it and clawed our way to the ANP role, to be recognised and trusted by patients.*
>
> *Jane: It seems they're saying, "nurses do it well so let's bring everybody into it". They're making us all the same and it seems like nurses are forgotten…again.*

### 4.4.2 Titles and Protections

The title transition from ANP to ACP did not rest easy with the majority of the participants due to the aforementioned reasons of being recognised as a nurse and the ACP being perceived as a generalist, multi-disciplinary role. The introduction of a new potential title, in addition to the multitude of advanced nursing titles was seen to be a backwards step, as Rachael and Jane elaborate:

> *Rachael: We've got enough titles going around. Why they've added another I don't know. Patients and GPs have got used to the ANP role and what we can do, just about. Now there's a big change to everyone being ACP. How is another title going to help?*
>
> *Jane: Over the years I could call myself anything. I could be "advanced specialist nurse practitioner clinician matron specialist" if I wanted. Nothing to stop me. Now there's another role and title. Doesn't really help things does it.*

The introduction of the ACP appears to have been developed without the knowledge of the participants as Adelle highlights:

> *Adelle: I've asked around here and at meetings and no one really knows about this framework or what the ACP thing is about. I know the new ANPs are calling themselves ACP but we're not sure why. I think it's the name of the course.*

The multi-professional education of ACPs was seen to be a positive factor in enabling multi-professional working, although several participants recounted the word "nurse" not being mentioned in the training:

> *Lindsay: The ACP course has every kind of profession in it now so they can't cater for all nurses like they used to do. My problem is there's not much mental health in there, it's all physical examinations. Getting everyone in a room and training together, all the different professions is good but losing the nursing side of it is a step back, I think.*
>
> *Diane: When everyone's training together it does get them talking and working as one, in a teamwork kind of thing. But I trained by a nurse lecturer, professor and in a room with nurses to be an ANP. We related everything to nurses and medical assessment. That might be lost.*

Debbie goes further when discussing the ACP university training, and the apparent discouraging of individual professional backgrounds:

> Debbie: I've had 3 ACP trainees now supervising them. All have said that when they're at university they're told to leave their professions behind as they're ACPs now and need to think like ACPs. That seems wrong to me, we should build on the professions, not abandon them. They're from different universities as well.

There appeared to be widespread confusion regarding the ACP role and what the title entails. This confusion worried the ANPs regarding acceptance, patient recognition and employability:

> *Jane: When you go for a job as an ANP, the GPs know now what it's about. There's always the dodgy ones who aren't really qualified, but if you're experienced they know what you're capable of. This new role and title is going to stir everything up and confuse them. With so many changes happening a new title and role might upset things.*
>
> *Lynda: For me it means losing the nursing side of it. All the different roles will be working to the ACP title and losing what nurses bring to it. Patients won't know what an ACP is.*
>
> *Sue: I'm all for any profession advancing and doing new roles. But we've got so many titles and people doing different things, it all needs sorting. A new title is the last thing we want. We've got GPs, ANPs, practice nurses, HCAs, a pharmacist and receptionists get confused about who to book with now. Patients booking online don't know who to book with. Imaging saying, "I'll book you with an ACP", they're not going to have a clue.*

This section has demonstrated the confusion around the ACP role, the unintended ACP title and the implementation. ANPs were concerned that they may be adopting a new title with no further regulation or protections. There was a clear indication that universities were not embracing the individual backgrounds of advanced practitioners, instead opting for a generalist ACP model.

## 4.5 Summary

Thematic content analysis of rich interview data resulted in three themes emerging from the data: *changing role, national strategy* and *identity*. Although ANPs considered their role to be evolving at pace, especially over the past several years, they described ongoing issues around role identity and the “medicalisation” of the role. As they moved increasingly into the medical domain, they questioned their identity and status within their organisations. There was recognition that they were no longer purely nurses, but taking on more of a medicalised, hybrid type of role.

They considered their status as nurses to be of paramount importance to them, but paradoxically, they highlighted that the role is distinct from that of the traditional nurse, occupying a middle ground between the nurse and doctor domains. This troubled them, as they recognised that they were abandoning many of the traditional nursing elements, although they relished the opportunity to expand their role and continue their transition. The adoption of new medicalised practices and their role expansion was seen to be as a result of decreased numbers of GPs and increased demand.

The introduction of the ACP role and framework further concerned the ANPs as they saw the role potentially becoming more generalised, working to a framework, and becoming less able to adapt and innovate due to possible strict guidelines. ANPs were able to adapt their roles and practices to suit individual organisational demands and were concerned that a standardisation of the education and practices of the role may inhibit the fluid scope of their role.

The findings of this chapter demonstrate that the workforce is adapting to circumstances rather than policy and strategy. It may be the case that a hybrid professional is emerging drawing on the skills of both the nursing and medical professions, with allied professions now joining the mix. The 2019 GP contract and the

HEE framework may be the first step in this process, introducing the unintended title of ACP, which may eventually incorporate the ANPs into a more generalised role.

# Chapter 5

# Findings and Analysis

## Phase 2 Interviews

## 5.1 Introduction

This chapter will present the findings of the phase two interviews with ANP managers, commissioners, GPs, and other key stakeholders around the ANP role. Analysis of the phase two interviews resulted in three main themes emerging from the data:

*1. Strategy*

*2. An essential role*

*3. An uncertain future*

The methodology of this study was not to approach the phase two participants with verbatim quotes from the ANPs and obtain their responses or use the themes from phase one as direct interview questions. Rather, it was to approach phase two with the knowledge and analysis of phase one and use them as topics for discussion. The analysis of the phase two data was undertaken separately to phase one, with the codes, grouped codes, categories and themes being developed independently from the previous group of interviews. Broad discussion themes around advanced practice, strategy, direction of travel, service design, role identity, training and patient demand were used to engage the participants and provide talking points, drawing on the thematic analysis of phase one but having an independent element. My own experience with service design did not include workforce modelling or strategies for personnel development on a wide scale, and I was keen to study the extent to which ANPs were considered when making key decisions. An additional area of interest for me, in light of the phase one findings, was the views of the participants on ANP development, medicalisation and the introduction of multi-professional ACP roles, with nurses losing the ANP title and a perception that they were moving away from a nursing model.

The first dominant theme developed through the data, *strategy*, suggests that there are attempts by key stakeholders to recognise the variability and lack of scope for ANPs, and to develop a framework for advanced practice and move towards this being adopted nationwide. The data also suggests that the participants recognise the need to enhance multi-professional working within primary care and general practice, although the strategy appears disjointed and unclear in key aspects of implementation.

Workforce analysts and commissioners expressed concern regarding the multitude of professions moving into the domain without a clear understanding of the scope and titles of the role. There also appears to be conflicting accounts of the current national strategy and contrasting views on the direction that regulation and standardisation should take.

The view that the ANP role was *essential* was developed as the second major theme. Managers, GPs and commissioners were keen to express the view that the role is now embedded within general practice and it will only expand further in the years to come. The participants felt the reduction in numbers of GPs would continue in the current climate of patient demand, lack of investment, and a perception that general practice is not currently seen as a viable career option for newly qualified doctors, so advanced practitioners from all professions would be needed to fill the gaps. This recognition of the role within GP surgeries was recognised by all the participants, although the reasons for the role not being referred to in national contracts or high-level discussions on primary care policy highlighted contrasting views.

The third major theme suggests that ANPs and multi-profession advanced practice in general has an *uncertain future*. Recent policy developments such as the HEE framework for advanced practice (2017), the RCN credentialing scheme, and the new ACP role appear to have added to the confusion from GPs, commissioners, managers and workforce strategists, with contrasting views being expressed. The 2019 GP contract provides funding for ACP roles, although the participants expressed doubts as to the effectiveness of these new practitioners, because of their working in networks rather than being embedded within individual surgeries, their availability in the healthcare market, and the unproven nature of allied professions being based within GP surgeries. The ACP role also provoked discussions on the exact nature of the role, its potential title and the merging of ANPs into the new format, with differing views on the implementation of allied professions within general practice and future workforce planning.

As in the previous chapter, each theme will be discussed in detail. Table 4 provides a visual representation of the themes and categories with corresponding examples of supporting verbatim quotes. This table provides additional evidence for the findings of this phase of the study. The themes are discussed with the participants' individual voices and experiences, traced through the data as supporting evidence. Thematic content analysis was once again used with constant comparison techniques (Charmaz, 2012; Glaser, 1998). Initial codes were merged to form grouped codes. An example

would be “needing a stronger voice”, “representation”, and “taken for granted”. These were grouped together into a higher-level code of “recognition”. Grouped codes were then formed into categories using the same process as in phase one.

Figure 8 shows the final data structure, highlighting the grouped codes, categories, and themes from which the findings were developed. Figure 9 shows a visual representation of the final themes of phase two, with subcategories also listed. As with the findings chapter of phase one, to enhance the trustworthiness of the data and the emerging themes, participants were sent copies of the grouped codes and early categories shown in Figure 7. This once again ensured that the concepts and themes resonated with the participants and they agreed with the findings.

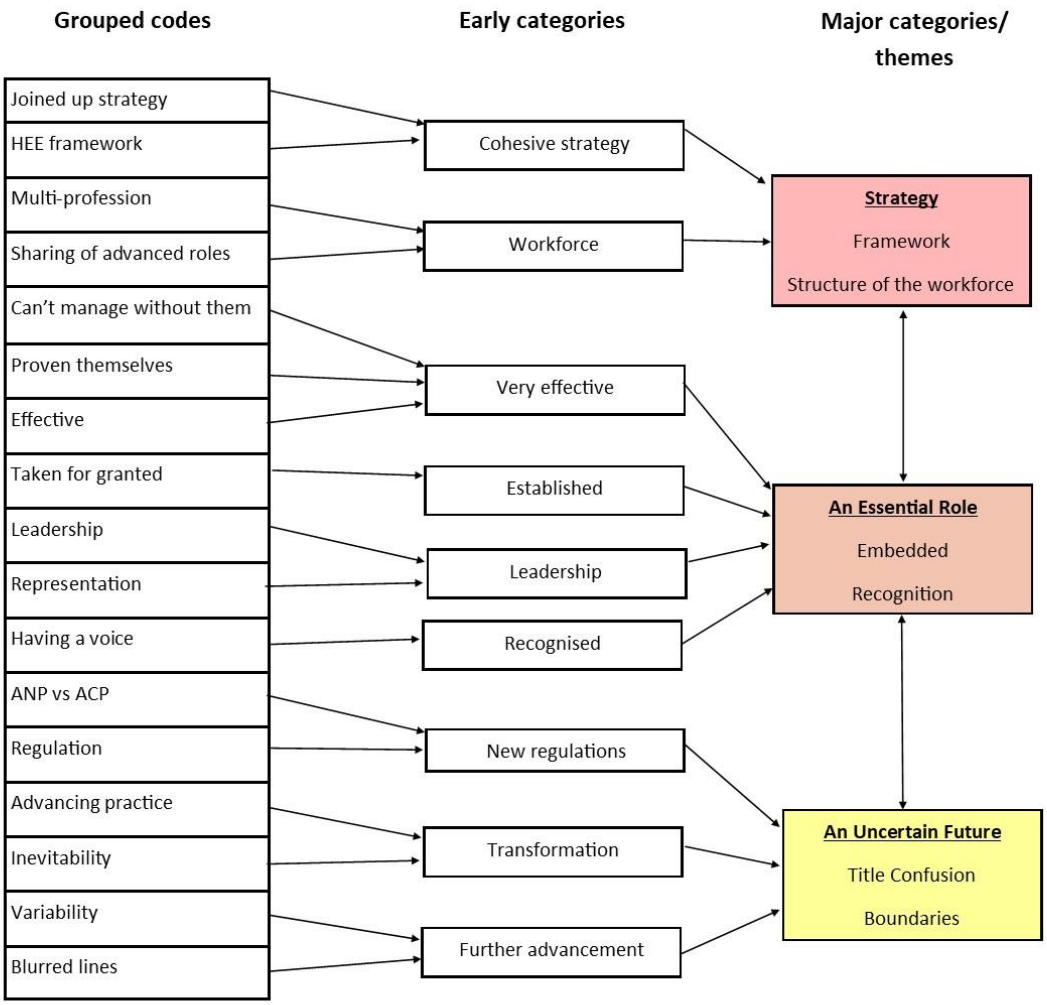


Figure 9 – Example of category formation – Phase 2

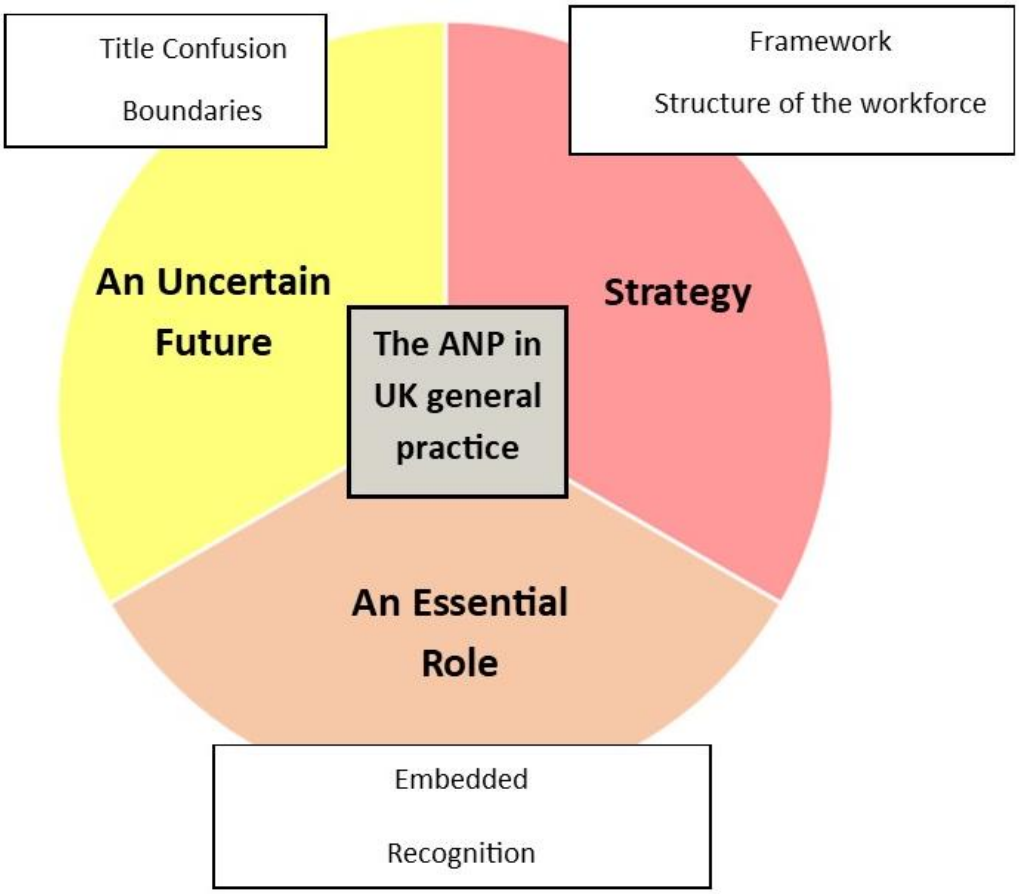


Figure 10 – Visual representation of the themes and categories – Phase 2

Table 4 – A visual representation of the themes and categories – phase 2

| Categories and grouped codes | Examples of representative data |
|---|---|
| **STRATEGY** | |
| **1. Framework** | |
| A: A joined up strategy | *A: "We might be reaching the point of a joined-up strategy with the framework but we've been here before and nothing's come of it. Time will tell"*<br>*A: "There's a distinct feeling that all the national bodies aren't really moving as one, they're saying different things sometimes"* |
| B: HEE Framework | *B: "The new framework for all advanced practitioners is promising but it's not mandatory and it'll probably take ten years to establish"*<br>*B: "There's definitely movement now on a strategy but anything could happen in the next one or two years. A change of government or other crises could derail it"* |
| **2. Structure of the workforce** | |
| C: Multi-profession | *C: "There's a move now that recognises multi-professions in advanced practice, not only nurses. We need to embrace that and promote teamwork more"*<br>*C: "Different professions training together can only be a god thing. How it works in practice is a different point. Nurses proved themselves over years"* |
| D: Sharing of advanced roles | *D: "Probably as nurses have embraced advanced roles and are very effective, its time others stepped up as well. Nursing lends itself very easily into these roles and allied professions can fill these roles as well"*<br>*D: "Advanced roles are now found in several professions. If they're all working at advanced levels, a strategy is needed. It'll get confusing and patients might not know who they're seeing but it's needed to improve access"* |
| **AN ESSENTIAL ROLE** | |
| **1. Embedded** | |
| E: Can't manage without them | *E: "ANPs are essential to service delivery. General practice wouldn't manage without them and when we're designing services or improving access, ANPs are always at the forefront of our minds"*<br>*E: "We have a large compliment of ANPs in our CCG. Both in hospital and in the community and GP surgeries. They're essential to improve access. I think the future will mean more of them".* |
| F: Effective | *F: "It's obvious that they're very effective and the patients are grateful. We have a walk-in centre in our CCG area for out of hours and the ANPs run this very well. I think the future years will be about advanced practice professions in these positions".*<br>*F: "The move is to get more professions into general practice not just the old GP and practice nurse model. We've got to change and open things up. ANPs have proven that they're effective and safe".* |
| **2. Recognition** | |
| G: Taken for granted | *G: "It's true that the contract was a missed opportunity and I don't really know how that happened. It's probably the case that nurses were taken for granted when these discussions were happening, which is a shame".*<br>*G: "The contract does mention practice nurses and education, but I know that a lot of people were very unhappy with it and the lack of representation for ANPs".* |
| H: Leadership | *H: "Nurses sit on a lot of boards and national groups but the ones when the money is decided, where the figures are divided up is lacking nurses. It feels like sometimes the leadership drops the ball when the big decisions are needed".*<br>*H: "There's nurses at every level of the decision-making process and if nurses feel* |

| | |
|---|---|
| | *left out then they should put themselves forward and speak up".* |
| **AN UNCERTAIN FUTURE** | |
| **1. Title confusion** | |
| I: ANP vs ACP | *I: "There is no ACP title, it's a level rather than a job title. It'll probably say something like ACP and then in brackets paramedic or nurse or physio".*<br>*I: "To be truthfully honest, we've talked briefly about this at clinical cabinet meeting within the CCG and we're not really sure what this all means and where it's going. The ACP, contract, and new titles is confusing, but we'll see where it all goes and how it pans out".* |
| J: Regulation | *J: "We can't see title regulation coming anytime soon without an amendment to the act in parliament and they're all busy at the minute with Brexit. The NMC are very lukewarm on regulating titles and adding a new register for ANPs".*<br>*J: "The framework will help to set the benchmark and the RCN credentialing process helps but they're all skirting round the edge really of proper regulation of the role".* |
| **2. Boundaries** | |
| K: Advancing practice | *K: "Everyone is advancing all the time. Nurses are advancing and taking on new roles all the time and that's great. All professions are adapting to changing demographics and changing numbers of doctors and GPs. It's good for the professions to advance"*<br>*K: "Newly qualified nurses will be advancing straight out of university so ANPs need to advance further to keep up. That's why the masters level qualification is so important. All professions are going to have to take on more and adapt".* |
| L: Inevitability | *L: "The boundaries will definitely continue to blur. Less and less doctors and more advanced professions is the direction of travel. There's an inevitability to it with the number of patients and a very tight budget".*<br>*L: "I think nurses will always be nurses and proud to be a nurse, but the role will change over time. With nursing associates and other roles coming in, nursing will become more advanced and take on new duties. There's no reason why nurses can't train and do a lot more if they're qualified and capable. All professions will do more. The days of the doctor doing everything, and delegating are numbered I think".* |

## 5.2 Theme 1 – Strategy

The participants commenced the interview by describing their role and how it relates to advanced practice, workforce strategy and the ANP role within general practice. Several participants were directly involved with national nursing strategy, policy making and had leadership responsibilities for primary care nursing. Two participants had responsibilities for workforce strategy planning and were involved in the decision-making process for general practice workforce policies.

There is a widespread view that there has been a lack of a cohesive strategy for advanced practice within the UK (Kooienga and Carryer, 2015; Bryant-Lukosius et al.,

2004; Lowe et al., 2012; Pulcini et al., 2010). The participants recognised this issue and related it to local concerns as well as the national approach. A locality workforce strategist had the following thoughts on the local and national strategy for advanced nurses:

> *Local: We're collecting a lot of data at present and analysing all the numbers. Previously we've relied on second-hand data and only what people tell us. Now we're taking data from practices themselves and analysing it. The issues are who's going to look at the data and use it. I'm working with a few CCGs at present and they've commissioned this work, but they don't know what to do with the results. I'm not even sure who I'm feeding it back to. It's the same nationally as well. The data is hit and miss and there doesn't seem to be any one person or maybe an organisation with responsibility for analysing it and coming up with a plan.*

The workforce strategist was commissioned by several CCGs to undertake workforce planning, benchmarking and strategy analysis. Once this data was obtained, there was uncertainty regarding how it was to be used and how it would influence local policy. As each general practice largely works in isolation, adapting to individual needs, it may be that the data was inconsistent and variable. The issue of reliable local data and its usability was also reiterated by a national workforce strategist who had a central responsibility for workforce planning:

> *National: It's very difficult to get information on who's doing what, their training needs, things like titles and their job descriptions. Each practice is like its own business and responsible for their own practices and staff roles. We rely on practice managers relaying the information in surveys but sometimes even they have different ideas on what the titles are and who's doing what. We just don't know accurately how many of each role there is out there, so it's hard to come up with a strategy.*

The above response appears to reiterate the previous chapters' findings that workforce changes are happening organically, dependent on local needs and demands on services. This obviously has implications for a national strategy which is dependent on accurate information. As practice nurses and ANPs expand their roles and take on new areas of practice, this data and change may be difficult to capture in the current system. Having reliable data on the numbers of professions in primary care staff doesn't provide any additional information on their individual roles and responsibilities, as a CCG lead nurse highlighted:

> *(Local): Well, we don't really know, or we're not aware of detailed stats on the numbers. We also don't really have any detailed figures on who's doing what and their levels. There's a lot of ANPs out there but the information on their roles and what exactly they're doing is very basic and not really accurate. It would be one thing to get a number of the ANPs working but that doesn't tell you anything about their roles and what they're actually doing.*

As the current system the CCGs were using mainly collected the numbers of staff, details of their individual roles, responsibilities and changing practices was being missed. A lead nurse from a separate CCG has similar concerns regarding the lack of information on roles and responsibilities. She also expressed concerns regarding the lack of detailed information, and the training and support needs of individual staff members:

> *Local: I act as a lead nurse within this CCG for all practice nurses, which includes ANPs obviously. Even within this one CCG we don't really know how each ANP is working and the types of responsibilities they've got. We know the numbers of titles as the managers tell us it, but that can sometimes not be right as well. If we don't really have accurate information on the exact responsibilities they have and the types of roles they're doing, we can't do a lot of modelling or planning for training or support and that kind of thing.*

A separate CCG lead nurse describes the lack of detailed information on roles and responsibilities, and describes the additional ways in which the CCG are made aware of ANP role change:

> *Local: We don't collect official figures or stats on the ways that ANPs are changing their roles but we do hear a lot from the meetings, training events and when we visit practices. We're always learning about how ANPs are doing more and more things and taking over different areas…just not in any official data collection type of ways.*

The issue of obtaining accurate data on ANP practices was linked with a local and national strategy for advanced practice. If there was to be a national framework, strategy or benchmark, there were concerns that it may run the risk of destabilising the workforce if it doesn't reflect the real-world working practices of ANPs. This was highlighted by the CCG lead nurse:

> *Local: Sometimes I wonder about the strategy and if it's better to just leave things as they are. ANPs in our area are doing amazing things and taking over more services. Any guideline or framework would have to take all this in mind and still let ANPs do all these new services. If we in the CCG don't keep track of every practice in our patch, how can the NMC or RCN or, like, NHS England keep track?*

The previous response highlights the lack of accurate information, both locally and nationally on the practices of ANPs. It was difficult for local CCGs to obtain this information beyond first-hand accounts or anecdotal evidence. This would possibly be even more difficult at a national level. The lack of detailed ANP workforce numbers and the scope of their role were again linked to the inability to develop a clear workforce strategy according to the CCG executive clinical director:

> *Local: Yes, we're a bit lacking on information. We rely on practice managers completing a survey every quarter. This can be hit and miss and not very accurate as sometimes they just list the number of nurses as a whole, which includes ANPs and sometimes they don't. Other times they group ANPs in with other staff groups like physician associates or junior doctors. It's hard to develop a strategy without having a grasp on what's happening at a practice level. If it's difficult at a CCG level, then that's probably why there's been a lack of a strategy nationally for so long.*

It is an interesting issue that the clinical director raises, that the lack of clarity and national strategy is possibly linked to not having accurate numbers of individual roles and the practices they undertake. Relying on practice managers to interpret titles, roles and scope appears to be a flawed method of collecting the data, but it is the only method they have. When this data collection method is combined with a myriad of titles and a lack of regulation, perhaps it is unsurprising that developing a cohesive national strategy appears difficult.

In addition to the lack of accurate local information, the national representatives also linked the lack of strategy for advanced practice to accurate workforce information, as the RCN representative emphasised:

> *National: I think hospital data on ANPs is more accurate than general practice data due to the problems of each practice being its own separate organisation, even then though the data in hospitals can be unreliable. The RCN are trying to represent all nurses and take advanced practice forward. We'd like advanced nurses to come forward and engage with the process and get involved. Over the years there's been a mixed strategy from all the key institutions. It might be moving forward now though with credentialing and the HEE framework. Events move really fast though and practices are changing all the time.*

The "events moving fast", as described by the RCN representative, include the HEE framework and the RCN credentialing scheme. These policies are currently voluntary and, as the phase one findings show, ANPs are not currently engaging with these processes and appear to be forging their own path. This may represent contrasting views between the two groups on the strategy for advanced practice and has implications for local adoption of a single model. The multitude of national bodies involved with developing ANP strategy often demonstrates disparities between the organisations and creates confusion amongst the workforce as demonstrated with the findings of phase one. The individual organisations involved include HEE, RCN, NHS England and NHS employers, as well as local and regional bodies. These often produce their individual frameworks, guidelines and policies on advanced nursing practice which appear to have little impact on the real-world working practices of ANPs, as shown in the previous chapter.

The issue of a confused national strategy was highlighted by the national nursing representatives. An NHS England lead nurse described the issues around advanced practice strategy, evolving ANP practice, the additional ACP role, and nurses advancing in general:

> *National: There's also the issue of titles. The ACP role isn't a title, but it's now seen as one. It's about advancing practice. I agree that general nursing is advancing, and we have to define this as well as ANP practice. It might be something like saying your title is "ACP" and then in brackets "nurse" or "paramedic". There's discussions as well about having an "advancing" nurse title for nurses who are taking on extra roles but not ACPs...I know it's confusing. There's a lot happening at the minute nationally and it can be hard to get a clear picture.*

If the scope, title, and practices of ANPs is unclear, the above response adds to this confusion by referring to the ACP role as a new title and then the possible introduction of a new "advancing nurse" title for nurses who are not quite ANPs. The admission that this process was confusing, was also shared by the national workforce representative:

> *National: To be honest it's a bit of a mess isn't it. It's like the cats out of the bag and we don't know how to define it or pull it all back together. There's too many titles and practices to keep track.*

The notion of ANPs advancing and evolving, and the national leadership wanting to "*pull them back together*" as "*the cat is out of the bag*" is an interesting phrase and may indicate a lack of control by the national leadership who are seeking to reinstate their influence over a workforce, which is largely disinterested in a multitude of guidelines. The representative from HEE also described the confused nature of advanced practice and the present strategy. She appeared to disagree with the RCN lead on "events moving fast", and instead described a lack of a national joined up strategy:

> *National: The issue is we've not got a cohesive joined up strategy at present. The framework is an attempt to rectify this by ensuring all ACPs are adhering to a set of rules and scope. It's not about saying this is your title and role but making sure no one is working at an advanced level who shouldn't be...I agree its voluntary and doesn't fully solve all the problems but it's the first step. The issue is there hasn't been a strategy which is why we've ended up with confusion and variability in the role. Any nurse can call themselves an ANP or specialist really. We've got to rectify that but solving it is difficult and it'll take time.*

It is interesting that the HEE representative admitted that there hasn't been a strategy up to present. It is also important to question who the responsibility should lie with for developing a strategy and defining a scope of practice; HEE, the RCN, NMC, NHS England, or the responsibility remaining with local employers as it is currently. When

asked about this point, the RCN representative appeared to disagree with the HEE participant regarding the lack of a cohesive strategy:

> *National: It's not that there's never been a strategy, the RCN have always been defining what ANPs do and we further developed the four pillars and with credentialing we've standardised what ANPs should be working towards and the level of practice. It's up to ANPs to make sure they're practicing at the right level for their qualifications and their scope. Each nurse is responsible for their practice. The RCN can only go so far though. It'll need the NMC and the government to take a hold of it.*

The above response from the national RCN leader implies that ANPs should practice within their scope and training, which is obviously correct. But it fails to demonstrate an awareness that ANPs are pushing the boundaries of their practice scope and moving into new areas, often largely medicalised in nature, which may not sit within an established framework. The ANPs in this study were not overly concerned with the four pillars of advanced practice or the RCN credentialing scheme. They were instead, concerned with local services, maintaining access, and expanding their roles in light of the reduction in GP numbers. These factors were absent from the responses of the national leaders.

There appears to be a discrepancy in the views of two of the nursing leadership participants regarding the national strategy towards advanced practice. With the RCN indicating that there are fast moving events now in place and a strategy developing, and the HEE striking a more cautious tone. The RCN lead also appears to pass some responsibility to the NMC and the government. There may be several possible reasons for this including them not being aware of each other's approach, having differing views on the way forward or having contrasting priorities. When the NHS England representative was asked about the possible different approaches to regulation and strategy, she appeared unaware:

> *National: I'm not aware of any major differences but there's a lot of agencies involved in it. The RCN obviously have the credentialing, and that's ok, but we're focusing on the HEE framework now. I'm not aware that there's any major conflicts. The RCN have their own agenda I think which is for them to sell, but the overall direction is probably with the framework. They're all doing the same type of thing and I don't think there's any disagreements.*

It is interesting that the NHS England representative appears to not be aware of any major differences between the key bodies and describes the RCN as having their own agenda, implying it is separated from the overall strategy. This is perhaps due to the voluntary nature of their credentialing scheme and the financial cost to ANPs. The fact that several key agencies were involved, overlapping, was also dismissed as a concern:

*National: There's a lot of factors at play and there's obviously different areas involved. We want to get it right so it takes time. Each organisation has its own views so we have to reach a consensus. Each one can have their own policy though and as long as its clear its ok. I don't think we're there yet.*

This response also differs to the RCN lead who indicated that events and strategy were now moving fast with key schemes in place. The above responses indicate that a strategy for advanced practice is not yet fully developed and requires more development to reach a consensus. The local commissioners, lead nurses and GPs were unaware of any strategy which would impact ANP practices or that events were moving fast, as the GP participant illustrates:

*Local: I'm not aware of any strategy really for ANPs. The GP contract mentions ACPs and pharmacists but that's all I'm aware of. The nurses here haven't mentioned anything.*

The multi-agency attempts to define advanced practice (RCN, 2012; HEE, 2016) and develop a framework for all professions to adhere to, doesn't appear to have been communicated effectively to CCG commissioners and lead nurses, as the responses below demonstrate:

*Local: Within the CCG we're really confused about where this is going and the new ACP roles. We leave it to the individual professions and the actual people employed to demonstrate they can carry out the role. GP employers are responsible for ensuring the staff can carry out the roles. We don't know where the ACP role is going, only time will tell. The framework you mention, I've not heard of it, sorry (CCG clinical director).*

*Local: I've not heard of a framework for advanced practice, but it sounds like a good idea, as long as it doesn't limit anyone. We have really good ANPs here who are always keen to expand and take on new roles. It's sometimes the case that a new framework or set of rules can limit everyone from innovating...I've not heard of this though and the ANPs haven't mentioned it (CCG lead nurse).*

The issues around advanced practice strategy as a whole are evident in the above responses. Organisations at the national level have conflicting views with some claiming progress and a strategy in place, whilst others indicate the process is just beginning. There is also the confusing situation where differing agencies and bodies have produced their own framework and scheme for defining and attempting to form a strategy for advanced nurses, often appearing to compete with one another. Local policy makers and stakeholders are unaware of the moves that seem to be going on a national level. The issues highlighted in the responses above, of a lack of communication between national bodies, general practice and CCGs, and a set of guidelines or a framework for advanced practice being seen as possibly limiting innovation, was also highlighted by Marsden et al., who, in 2010, suggested that

localised flexibility and adaptability are key to ANP role development and innovation rather than poorly communicated fixed guidelines or a narrowly defined scope of practice. They added that attempting to standardise ANP practice may result in a less responsive workforce that is less innovative. Little appears to have changed in the ten years since this publication, with a national strategy and title protections still not in place, and, as evident in the phase one findings, ANPs expressing concerns that the standardising of their role would stifle adaptability and innovation. It may also be the case that, following multiple frameworks and guides, ANPs ultimately reject or ignore any new strategy and any attempt to standardise their practice.

The responses in this section suggest a lack of communication regarding ANP and ACP strategy between national bodies such as the RCN, HEE and NHS England and general practices and CCGs. The issue of accurate data being available regarding the numbers of ANPs, their working practices, titles and roles appears to be not only a local issue but may also be feeding into the national problems around developing a cohesive strategy. Various policies such as the HEE framework (2017) are attempting to define the appropriate level of not only nursing advanced practice, but allied professions undertaking advanced roles, although this framework does not regulate any of the titles used in these posts. The national strategists and policy makers appear to be claiming that there is a lot of movement on a strategy, but this is happening in a sphere that seems divorced from what is happening locally at a regional level. The phase one findings highlighted a lack of understanding amongst the ANPs regarding what was happening at the national level and ANPs continuing their role expansion and development regardless of any national policy drivers. The commissioners, GPs and local leads recognise that the ANP role has grown and developed organically and continues to prove itself, despite any detailed local statistics. The shape and scope of the role may be different to what the national leadership believe and may limit the effectiveness of a national framework.

### 5.2.1 Framework

As previously discussed, the 2017 HEE framework sets out a structure for multi-professional advanced practitioners to adhere to, ensuring they are appropriately trained and qualified to use the title “advanced”. It does not define the titles used in advanced practice such as specialist nurse, ANP or ACP, and is independent to the RCN ANP credentialing scheme. It also doesn’t define the scope of advanced practice.

CCGs and general practices were unaware that the national bodies are active in their policy development including the HEE framework and the RCN credentialing scheme. They do however have views on the introduction of a framework or credentialing scheme. A GP employer described his feelings on a national framework and the move towards a cohesive strategy. He reiterates the issue of a lack of communication whilst expressing scepticism regarding the effectiveness of a framework:

> *Local: I've been around long enough to see a lot of national strategies come and go over more years than I'd like to mention. It's usually the case that when the strategy is launched after years of talking about it, and it's up and running, everyone else has moved on and it's then out of date. I've not heard of this one, I'm not sure the nurses here know or not. These strategies and frameworks and guidelines are usually restrictive and cautious by their nature as they're trying to make everything as safe as possible. It could end up restricting things. I'm sure in five years we'll have moved on and they'll be talking about a new framework.*

This scepticism around a national framework and its ability to reflect current practice is also evident in the responses of the CCG nursing leads, who describe their thoughts on a national *one size fits all* framework for advanced practice. Their responses highlight the confusion and lack of knowledge at regional level, showing a mixed picture of nurses and allied professions in a multi-professional combined role, and the presumption that the ACP is a role and title, not only a level of practice:

> *Local: Within the CCG we don't really know what's happening with the ACP role and how this fits with ANPs. We've not got any working in our area…we do have advanced prescribing pharmacists, are they the same thing? They don't call themselves ACP though as far as I know but they might do. If all the ANPs and the others are going to be called ACPs then we might not know who's doing what, kind of thing. They might be trying to make a one size fits all kind of rule about ACPs and ANPs. I think nurses as ANPs are recognised and they've proven themselves, so it remains to be seen what's happening with the roles, we don't have any real understanding of it in the CCG though.*

> *Local: I'm aware that there's a move now to get all professions into advanced practice and not only nurses. I think nurses have done that kind of role for decades though and we're damn good at it. It seems like it might eventually be that everyone's an ACP and doing the same role. It'd be a shame that though. Most advanced nurses are called ANP though aren't they, I'm not sure how they'd feel changing to the ACP title and being grouped with physios and pharmacists and others. You mention strategy and I think the strategy is to move towards that isn't it. There's no plans in the CCG though and we've not really engaged with it yet, we're just waiting to see what happens nationally and if there's any guidance.*

These senior local representatives demonstrate a clear lack of communication between national and local bodies on a strategy for advanced practice, ANPs and the ACP role. The introduction of the ACP appears to be causing confusion, especially with the established ANP workforce. The notion of "waiting to see what happens" is interesting

as it risks nothing happening at all, if the lack of communication between the two sides local and national, is widespread and continues. It is also interesting that they refer to the ACP as a title and question whether ANPs will naturally adopt it, further demonstrating a lack of communication and direction. There was no presumption that ANPs will adopt the new (albeit inadvertently introduced) ACP title, especially amongst the ANP participants. ANPs were protective over their nursing background and titles, although they recognised that they were advancing beyond the traditional nursing domain. Both CCG lead nurses demonstrated a distinct lack of understanding around ACP education and the HEE framework. This framework doesn't set out a title or period of transition from ANP to ACP, but there is a clear concern amongst the ANP participants in the previous chapter, and the lead nurse responses here, that it sets out a path towards this amalgamation. The HEE representative attempted to describe the current national picture of advanced practice strategy, but appeared to reiterate the confused approach to defining the role, including the issues around the scope of practice, how the ANP fits with the ACP role, and the timescales for implementation:

> *National: There's a lot of work going on in this area at present and I'm not surprised ANPs and employers are confused. The HEE framework is about setting a standard for all advanced clinicians to work to the same level whether you're a nurse or another profession like a pharmacist or physio. It not about scope or titles. The ACP isn't a title but it's being used as one now. Nurses can still use the ANP title, there's nothing to stop them but they can use the ACP one as well, but it's not really meant for that. It'll take a while for it to be implemented and we're not about chastising anyone but offering them help to move towards the standard. It's voluntary though but it may be that employers use it as a way of ensuring they're employing people that are appropriate. It's about safety as well. The RCN have their credentialing but that's for nurses only and nothing to do with the framework, although they're based on the four pillars though.*

The HEE (national level) representative appears to occupy a different world from those at regional or local level. The notion that the ACP isn't a title, that nurses could use ANP or ACP titles, and that the framework is voluntary, further adds to the confusion, especially at a local level as demonstrated in the previous responses. It is unsurprising that local policy makers are confused as to the role and implementation of ACPs and where they fit with the established ANP role. The voluntary nature of the framework and the response that the RCN credentialing scheme is "nothing to do with the framework" is interesting if the national agencies are to develop a cohesive strategy and communicate this effectively to local areas. The responses may indicate an almost competitive way of working between the national bodies, with each organisation attempting to ensure that their framework or strategy is more important. A CCG commissioner appeared to cast doubt over whether any framework would ultimately impact on ANP practice:

> *Local: There's a tendency with these things where a guideline is introduced, and everyone just carries on regardless. We see it a lot. Unless there's some kind of forfeit if you stray from it like a target, or even a financial incentive then guidelines run the risk of coming and going. Increasingly we're planning our services with the ANPs and ACPs in mind, not just GPs. I can't see that changing any time* soon.

The HEE representative was nevertheless keen to promote the multi-professional framework as a strategy which could resolve the confusion and misuse of advanced roles and titles:

> *National: We have to recognise that there's several professions now coming into advanced practice and being trained alongside nurses. So, to ensure they're all working at appropriate levels, we need to develop the framework for them to work to. The ACP course isn't a title or a scope, it's a level of practice. It's in development and it's not been launched yet, but we think early 2020 hopefully.*

It is confusing that the representative asserts that the framework will be published in 2020 when it is available on the HEE website for download and forms the basis of university ACP education. This may indicate a revised version may be being worked on or that the actual implementation regarding clinical practice would begin in 2020. When this representative was pushed on the implementation strategy for the framework and timescales, they appeared unsure of these details, and seemed to once again refer to the role using ACP as a title:

> *National: The implementation of the framework may start as voluntary and maybe in time there'll be a kind of online register or database of ACPs. It'll take a while for this to filter down and for professions to adapt to a new way of working. We need to give time for people to adopt the framework and maybe do training to ensure they fit with the guidelines and don't stray from it. It's not about re-banding anyone or demoting them, but we need to ensure safety and make sure they're all working the same. We're anticipating it'll take a while to implement, maybe 10 years or so.*

The above quote is very important. The interviews with ANPs showed that ANP growth and development has been organic and dependent on local needs. There is an assumption amongst the national leaders that they can define the roles, duties and scope, and expect all ANPs and ACPs to conform to its definitions and practices. This may contradict the local innovations and development of ANPs with the assertion that *"we need to make sure they're all working the same"*, something that was a clear concern for ANPs, local commissioners and GPs who value a fluid and adaptable role. Advanced practice is a pragmatic response to local conditions and pressures, and practices may differ widely between localities.

The actual implementation of the framework is another area of confusion. There was no clear plan for how or when a framework would impact practice, only the possibility of a

register or a time when all ACPs would work “at the same level”. The prospect of a ten-year implementation for the framework was questioned by the GP participants:

> *Local: Whenever I hear that something being implemented in the NHS is going to take 10 years, I immediately know that we'll never see it done, or it'll never get actually implemented. Something else will replace it in a couple of years or it'll just be forgotten about. I've seen it many times.*

> *Local: I don't know much about it but if, as you say, the framework for ANPs will take ten years to implement then I don't hold out much hope. That's two general elections, probably different commissioners and managers and most likely two complete NHS reorganisations in that time. There's always a lot of talk and policies and guidance coming out, but I think only about 10% of all these things are ever completed. Our ANPs are working really well and we wouldn't be without them. Interfering with what they're doing could affect them and make them question what they're doing. It might not be good for morale to interfere and question what they're doing.*

A top-down approach is clearly questioned by the GP employers. The pace of change amongst the workforce and the expansion of the ANP role, as shown in the previous chapter, may mean that the framework is obsolete before it is implemented. The responses suggest a disparity in the views between national representatives and those of clinicians in practice. The difficulty in implementing a new concept and benchmark for advanced practice without a definitive title, and incorporating several professions is evident in the responses of the GPs who will ultimately employ these practitioners, and will only do so if they have a clear understanding of the scope and value of the role. The local GPs demonstrate a reluctance to “interfere” with the role and duties that the ANPs in their practice are undertaking by introducing a new framework. This feeling of possible interference and the destabilising of the workforce wasn't evident in the prior responses of the HEE representative, who was highlighting their need to ensure the roles are working at the same level and standardised.

The multi-professional framework aligns itself with the 2019 GP contract in its emphasis on allied professions taking up posts in general practice. These posts are 70% funded by NHS England when they work at a network level. This is due to be updated in the 2020 GP contract and may raise the funding of the roles to 100%. The contract provides funding for primary care networks (PCN); a group of GP practices working in partnership to shape local services for a designated population up to 50,000. The ACP would not be employed by individual practices, but by the network, and their working time would be shared between the surgeries. The CCG commissioner described the 2019 contract:

> *Local: Well the contract brought in the idea of networks, PCNs they're called. The idea that ACPs will be working across the network is what's touted and NHS*

*England will provide funding for it when they're in post for a limited time. The thing is we in the CCG have tried using pharmacists working across groups of surgeries for a while now and it doesn't work. Any person like that needs to be embedded in the practice and work with the GPs and nurses there daily. Having them spread thinly across practices won't work.*

This response is further evidence of a disjuncture between the national level planning and the experience on the ground of clinicians and commissioners. The HEE framework attempts to standardise the differing professions working at an advanced level in both acute and primary care settings. The GP 2019 contract and the GP forward view (2016) set out the direction of travel for advanced professionals expanding their practice and taking on previous doctor-only roles. The RCN participant described the framework and its link with the GP contract, demonstrating confusion on the direction of travel for the two similar strategies from HEE and the RCN:

*National: The RCN have recognised the need for a framework for many years and we have the four pillars and the credentialing scheme. It's been good seeing nurses go through the programme. I'm not sure what will happen to the credential scheme if the framework is launched though, or if it is adopted by all ANPs. Maybe one will supersede the other but there'll always be a place for RCN credentialing, I think nurses want the recognition. Its more important now with ACPs coming in with the new contract.*

The responses suggest there is a lack of an inter-agency joined-up approach to advanced practice policy. This is in addition to the national/local disconnect. It is unclear whether this is due to differing views on the subject, the RCN monetising their scheme for nurses only, or the HEE framework being a voluntary register for all professions. There is also uncertainly in the above response regarding whether the HEE framework is actually "launched" or not and how it will impact ACPs in general practice. The RCN lead also refers to advanced professionals using the title of ACP. When questioned on the conflicting nature of multiple frameworks and credentialing and if this causes confusion with the GP contract and ACP roles, the RCN representative (in the first quote) echoed the thoughts of the workforce strategist (second quote):

*National: Yes, I think there could be confusion with ANPs about "do I use the credentialing or the framework". Although the framework is something to work to for the advanced level and the credentialing gives you the title of advanced level nurse. The NMC needs to play a part as well but they're not involved in the credentialing. They're making some noises about reviewing the register but that would need an amendment to the act in parliament to add a new register and I don't think that will be happening soon. At the end of the day, nurses need to ensure they're working at an advanced level and they're trained and working to their scope.*

*National: When we look at workforce planning and scope, I think you say, "what is this group capable of and how can we use them effectively". With ACPs and ANPs we're not really sure, partly as we don't fully know how many there are.*

> *When you see multiple frameworks and guidelines for the role and each one is a bit different you start to worry. For the average ANP working on the ward or in a surgery it must be a bit of a nightmare.*

The above quotes highlight the confused nature of the debate around ANPs, ACPs, frameworks and the scope of practice. The RCN lead appears to assume that ANPs will be questioning which framework or scheme to align their practice to, or that they may question if their level of practice is sufficiently advanced to warrant admission to a register or framework. The findings of phase one showed that ANPs have no such concerns and are advancing their roles, practices and duties with little regard to the HEE framework or RCN credentialing scheme. This is done with the support of local employers and commissioners, who are also confused around how these strategies will impact ANP practice. The notion of ANPs finding the lack of strict guidance on their role a "*nightmare*" is a clear contrast to the views of GPs, ANPs and commissioners, who welcome the fluid nature of the role and its ability to adapt. The key stakeholders appear to be issuing conflicting statements on advanced practice and the messages don't appear to be filtering down to ANPs in practice. It is also the case that the experiences and evolving practices of ANPs are not apparent to the national policy makers. The response from the ACP education strategist highlights these mixed messages:

> *National: Remember that the RCN are a trade union and the credentialing is about protecting their role and it also brings money into them. The HEE framework is more promising, but it's aimed at all professions so there's a risk it is too bland and may limit innovation. From the training side of things, we're looking at standardising the courses across England to make sure everyone's educated the same and to the same standard. We know that ACP isn't a title, but unfortunately everyone now sees it as a title for a role. Everyone coming out of the courses now call themselves ACP whether they're a nurse or physio or pharmacist unfortunately. That can get confusing for employers probably. It looks like no one really thought about the titles and how it would be used when the framework or the GP network contract was being drawn up.*

This section has highlighted differing views on the HEE framework for advanced practice, its usefulness, and the confusion around its implementation. Commissioners and GPs expressed doubts and concerns that a framework could be implemented nationally, and the long timescale could be prohibitive and become irrelevant over time. There appears to be a disparity of views on the responsibility of ensuring adequate qualifications, training, and whether the nature of the role carried out by ANPs aligns with the framework; the RCN suggesting that ANPs are responsible for their own practices, while HEE state that the framework would ensure ANPs are working at the correct level alongside allied professionals in advanced roles by possibly introducing a register in the future. There is also apparent disagreement on the role of the ACP and

how these fit with existing ANPs. The inadvertent introduction of yet another advanced practice title has led to the assumption that ANPs will be made to switch to using the ACP title, although the framework doesn't mandate or assume this. The disconnect between the workforce and the national policy makers is apparent on a range of issues. ANPs welcome their innovative, adaptable role, whilst the national agencies are pushing a framework and benchmark without a clear title or scope, and risks standardising the role, a move resisted by ANPs and their local managers and employers.

### 5.2.2 Structure of the workforce

A major factor in the current development of general practice is the move towards a multi-disciplinary team within primary care and the move away from the doctor centric model. Improving patient access and widening choice requires the development of pharmacists, physiotherapists and other allied professions (NHS General Practice Forward View 2016; NHS England, 2019). The change of the dynamics of general practice was a key issue for the participants, with contrasting views on the design, implementation and potential success of the policy. The NHS England representative describes the envisioned future model:

> *National: We're moving away from the GP being the centre of the service to a multidisciplinary model where patients can access…say a physio for back pain or a nurse for infections or a GP for multiple complex conditions. Opening it up will mean better access to appointments for patients and more staff working in primary care. We're on a journey and we're not there yet.*

The HEE workforce representative entered a word of caution on the availability of the personnel:

> *National: We do need to get more professions working in general practice, instead of the usual GP and nurse. Who better to deal with medication issues than a pharmacist or arthritic joints than a physio for example? I do worry about where all these people are going to come from though. It's not as though they're sat there waiting for GPs to employ them. The hospitals are already short of these people. If they're employed as a network as well, instead of directly employed by the practices, then it doesn't strike me as an effective model or maybe not a wise career move for those people.*

The perception of a lack of allied health professionals being available for employment in a general practice network is in line with findings from the Charted Society of Physiotherapy (2016) that highlight a serious shortage of physiotherapists in England in conjunction with an insufficient number of university physiotherapy student places. The

shortage of allied professionals wasn't highlighted by the NHS England participant. Despite a recognised difficulty in recruiting pharmacists and the 2019 GP contract providing funding for these roles, a government advisory committee in 2019 declined to add this profession to the "shortage occupation list", making recruitment strategies more difficult (Burns 2019). The CCG clinical director also expressed concern regarding the employability and availability of the professions to move into general practice:

> *Local: I'm a GP myself and I know that GPs are cautious about taking on new staff, especially ones where they don't really know how they work with it being a new role. Most likely they'll sit back and see how others do it. It's all about the funding as well. Practices are short, there isn't the money to start employing new ACPs who aren't proven effective roles. They now accept ANPs and know what they can do, they're using ANPs in all kinds of roles now as they trust them. It'll take a while for them to employ other professions on mass just because the new contract says they should. In the CCG we've tried to get pharmacists into practices doing medication optimisation and cost effectiveness strategies. They last on average about six to twelve months before leaving. They can't simply spend a day per week in each practice, it's not effective that way. We've had open recruitment advertisements for pharmacists for months and no one applies.*

The above statement from the CCG representative raises issues of employability of the ACP roles, an undefined scope of practice, and scepticism around ACPs moving into general practice in significant numbers without a proven track record. This realist view mirrors the concerns of the ANPs around losing their identity with the introduction of ACP roles. The commissioner recognises the track record of ANPs and highlights the role being utilised in various areas of service. If the new advanced roles are untested and ultimately prove ineffective, it may hinder the progress of ANPs by being associated with ACPs. This concern was highlighted by the CCG lead nurse:

> *Local: I suppose there's a risk that the new ACP roles don't work out or go wrong…create more admin and work for GPs. This could have an impact on ANPs as well if GPs say none of these advanced roles really work so lets go back to the GP model. That would be a shame. If its not adopted and it doesn't work it could mean less money for ANP training or a lack of interest from government as well.*

A CCG commissioner (who was also a GP) spoke of his concerns around allied roles not freeing up as much GP time as was anticipated:

> *Local: We had a part time pharmacist who we shared with our branch site. We assumed it would free up GP time if they did all the repeat scripts and meds queries. It didn't quite work out that way though in the end. They need support and training and supervision. It depends on the level of pharmacist and how much they're willing to engage.*

The experience of this CCG commissioner, of moving pharmacists into groups of practices to undertake a medication optimisation role is important when considering ANP and ACP roles within general practice. Their support and level of engagement are key to their success. It proved ineffective in the above example due to them not being based fully within the practices and able to shape their role dependent on organisational needs, instead moving around a group of surgeries and not being based within one organisation.

The GP participants discussed their concerns regarding new roles moving into general practice and how this transition would affect their own numbers and security. As with ANP representation at a national level, the GPs felt their own representation was not adequate:

> *Local: Maybe getting more types of professions in would be helpful but at the end of the day patients sometimes like to see a GP. The medical students and newly qualified doctors are not seeing general practice as a modern and sexy place to work. They like to have portfolios with research, teaching and that kind of thing. Becoming a partner and running a business is not what they want. These other professions that they're wanting to come in won't want to do that either. There should be a much bigger push to get doctors into GP training but for some reason they don't want to do it.*

> *Local: The GMC and BMA have helped develop this strategy. It's like turkeys voting for Christmas. We're doing ourselves out of a job. If patients are mostly going to see nurses or physios or pharmacists, then there will end up being one GP in each practice in the future. The BMA seem happy about this.*

The above responses also demonstrate a lack of communication between the local and national representatives, this time on the medical side. There is also an acceptance that the workforce is changing, and the model of GP partnership may be unwelcoming to newly qualified doctors, hence the need to adapt the workforce.

The issue of ANPs working alongside allied health professions was discussed with the relevant national nursing representatives. They dismissed the notion that nurses are protective over their advanced roles and the uniquely nursing approach to advanced practice. The ANP concerns regarding the generalisation of training appeared to be questioned by the nursing representatives when discussing the topic. The RCN representative expressed the feeling that ANPs should get involved in the discussion at a local and national level, rather than expressing their concerns:

> *National: Nurses shouldn't be jealous or afraid of other professions being equivalent to ANPs. They should step up and embrace it. If they're confused or worrying about the ACP thing then they should get involved in the forums and conferences and read all the information the RCN is putting out. In a lot of cases they don't though.*

This comment highlights the notion of ANPs being "jealous" or "afraid" of other professions taking on advanced practice roles alongside them, although this didn't appear to be an issue with the ANPs themselves in the previous chapter. The ANP concerns were around identity, standardisation and role recognition. They also had a reluctance to get involved with policy and strategy developments; they didn't have time to do this and wanted to remain clinical with patient contact. There may also be a subtle hint in the above response by the RCN lead of blaming the ANPs for not being fully aware of how the ACP roles will work due to their lack of involvement in policy making. This blame appears to be unfounded however, as the confusion around the ACP role is also evident in the responses of the local commissioners and GPs. The previous chapter highlighted ANP's concerns of universities disregarding professional backgrounds and educating advanced roles in a generic approach. The NHS England nursing representative also echoed the previous RCN lead's comments on nurses being concerned unnecessarily regarding ACPs, standardisation, and losing the nursing element of advanced practice. There appeared to be a denial that universities are training ACPs as generalist practitioners irrespective of their profession:

> *National: Universities shouldn't be referring to anyone as an ACP. It's not a title. They have to train them all together though on the course. Nurses get very worked up about titles and who's doing what. Other professions coming into these roles is a good thing. I don't think nurses stand up for themselves enough and speak with one voice. They can get involved with meetings and policy groups if they want. They're getting hung up about the ACP title but that's not what it's about. They can put whatever they want on their badge or on their door…I know that shouldn't be the case, but it is.*

It is interesting that a national nursing leader should express the idea that nurses are not "*standing up for themselves or speaking with one voice*". The previous chapter highlighted many examples of ANPs taking their roles and practices in their own hands and shaping service provision around the ANP role, often with the backing of GPs and commissioners. The above response demonstrates a lack of awareness of these changes, instead recommending that nurses get involved more with meetings and policy groups. The NHS England representative also demonstrates a lack of awareness around the ACP education and the adoption of the ACP title highlighting that advanced nurses should not be concerned about identity or titles and can call themselves what they want. The issues around ACP trainees being told to "*leave their profession at the door*" and "*think like ACPs*" when commencing advanced practice university courses, as highlighted by the participants in the previous chapter, was again dismissed by the ACP training strategist:

> *National: I'd be surprised if that was being said to anyone. Each profession has its own set of skills to being to the table. We want to celebrate each role and work as a team. Nurses are protective over their role, but they have to give and take a bit.*

When discussing the ACP roles in general practice, the notion that allied professions would be working alongside GPs and ANPs and possibly taking over previous ANP roles was elaborated by the NHS England representative:

> *National: There might be a case for say paramedics taking on more of a home visiting role for acute requests or maybe the pharmacist taking on more of a medication reviewing role. ANPs will adapt though and be able to move into other areas. It's about working as a team for what's best for patients. It'll be up to individual practices to determine who does what and what path to take with these roles.*

There appears to be a difference in opinion between national leaders and local representatives (the participants based within the workforce); between NHS England, national workforce strategists and the GP employers and commissioners. The nursing leadership appeared relaxed and more certain around the transition to an ACP workforce encompassing nursing and allied health professionals. In contrast, the local representatives appeared to express concerns regarding the unproven nature of a multi-professional role and the introduction of a new framework. The notion of it being "*up to practices to determine who does what and what path to take*" (NHS England) with the ACP roles appearing to be at odds with the GPs and commissioners, who expressed concerns regarding the availability and unproven nature of the roles when compared with existing ANPs. The self determination of GP surgeries may also be at risk with a national framework for advanced practice and the PCN contract, demonstrating a top-down strategy and possibly being out of touch with the realities of the workforce.

How the multi-disciplinary approach to general practice service provision will ensure safety and ensure accountability was discussed with the participants. When questioned on how patients will see the roles, the various titles, and how they will determine the background of each role, the responses highlighted contrasting views. A CCG lead nurse describes the issue:

> *Local: There's obviously more roles coming in and becoming part of the team. It'll be more titles and different ways of working. I'm not surprised existing staff are nervous or questioning who will be doing what kind of jobs. I think ANPs are comfortable in their role now and most are working at a really high level. I wouldn't want, say, a paramedic to come in and say, "right I'm doing all the home visits now" when an ANP has been doing it for years. It's not about upsetting anyone I don't think. We're all waiting for some clarity on all this*

*though. Patients are now very used to ANPs and seeing nurses for different things. They need time to adapt and trust anyone new.*

This response demonstrates awareness of role boundaries with the potential arrival of allied health professions taking over existing ANP roles such as home visits or triage. Clarity on the direction of travel and scope of practice around the ACP role is also required by the CCG lead nurse, as she expressed the need for further information. This discussion also reiterated the feeling that patients accept nurses in advanced roles. The CCG commissioner appeared to agree with the previous quote, adding that there is little guidance on how the roles will be integrated into the general practice team:

*Local: I think the teamwork approach and bringing in new roles is welcome. Everyone working in a team and taking on different aspects of care is a good idea. The contract doesn't say how to use them though or how they'll be integrated. The idea of network employment and spending a day per week in each practice clearly isn't a good idea. They need to be fully integrated into the team to be effective. Existing roles like ANPs or GPs will dismiss them quickly if they're not working. GPs are running a business and they need to trust the people they employ so they're naturally a cautious bunch.*

The response above highlights the contrasting views between the national leadership and the local workforce. There is a clear assertion that spreading new ACP roles thinly between various practices will not be effective. ANPs are successful because they are embedded within their organisations and are able to adapt their roles to local needs, a concept which appears to be missing from the responses of the national leadership.

This section has demonstrated a disparity of views between national figures and the local leaders on the changing general practice workforce. The implementation of ACP roles made up of nurses and allied professions was questioned by commissioners and GPs, with a concern that ANPs and the makeup of general practice may be affected by the additional roles, at a time of increased pressure and demand. There were concerns that the framework would be obsolete due to the pace of change and its voluntary nature would render it ineffective. There were also concerns that any attempt to restrict or define the scope of ANP practice would hinder the role's ability to evolve and adapt to local pressures. These issues were largely dismissed by the national representatives, demonstrating a disparity of views. The education of ACPs and the potential "abandonment of professional backgrounds" during their university education appeared to be denied by the representatives with a view that nurses may be worrying unnecessarily. Perhaps the HEE framework's current influence is felt most in the university setting, where all the professions are apparently referred to as ACPs and their practice risks becoming standardised, a clear concern expressed by the ANP participants.

## 5.4 Theme 2 – An essential role

In 2015, the chief executive of the QNI publicly called for ANPs to replace GPs where there was a gap in service provision (Oldman, 2015). She highlighted that nurses have many years' experience at advanced level practice and are a proven and essential role in general practice. This was at a time when physician associates were being touted by NHS England as a potential role for relieving the pressures of general practice; an unregulated role with no prescribing rights. Despite these shortcomings, they were recommended to be employed at a band 7 level, a level which would require many years' experience for a nurse to achieve. Despite ANPs being common in general practice, the NHS England encouragement of unproven advanced roles mirrors the current situation with ACPs. The current aspirational target of a GP appointment within 48 hours requires innovation and role development, especially in the present climate of falling GP numbers (Oliver, 2017). Oldman's (2015) assertion that ANPs can improve access, develop further skills and take on many of the traditional GP roles appears to already be in progress, as evidenced in the previous chapter. It also demonstrates the ANPs status as an embedded and trusted role within primary care, although possibly not recognised by the national policy makers. Paniagua (2010) reflects this by highlighting that ANPs are essential in broadening access to general practice and have more to offer in the future. A qualitative study by Long et al. (2004) demonstrated that the working practices and embedded workforce of GP surgeries has changed considerably over many years as ANPs became more established within general practice and took on new roles.

The participants in this study all recognised the significant role that ANPs play in maintaining and improving access to general practice. They recognised that in addition to improving access, nurses also act as specialists in chronic disease management and are increasingly taking a central role in many other areas of general practice including triage, home visits, telephone consultations, and the leadership and management of the organisations. The two GP participants describe how their ANP colleagues are utilised and the impact their roles have:

> *Local: We have a really effective nursing team here. The ANPs are really good and they see most things that get booked in. Their experience is important and they're able to deal with everything really. They do home visits, triage, end of life care…We wouldn't be without them really.*
>
> *Local: The ANPs here are utilised really well. The patients like the appointments with them as they're a bit longer than the GP ones. They do extended roles as well like diabetes and women's health. One of them does the home visits and acts as a manager to the other nurses. We're lucky to have the ones we have*

*here. We have a practice nurse who's training to be an ANP as well and we're supporting her. She'll build up when she's qualified and do the same roles as the other ANPs.*

The CCG lead nurses were also aware of the utilisation of ANPs, but there is a difference between their levels of awareness:

*Local: We're aware in the CCG that nurses are taking on more and more roles. They have to really as the GP numbers are slowly going down across the patch. It's not unsafe what they're doing and they're working in their scope and experience. We are aware of it though. Outside of the surgeries the community is using ANPs as well for out of hours and the walk-in centre. It's a good role to have when we're thinking about different services.*

*Local: When we have meetings with surgeries, they always say they're investing in their nursing teams. They're keen to get nurses on minor illness courses and ANP training…or ACP is it now? Some surgeries don't really have an experienced ANP and they're the minority now. Most have an ANP or sometimes a team of them.*

These contrasting quotes show that the knowledge the GPs have appears to be more practical, grounded in actual examples of ANP role expansion and advanced duties than the representatives who were away from the *front-line*. Although the CCG representatives were aware of ANPs taking on new roles, they appeared to lack any direct knowledge of specifics or how ANPs felt about this change. The GPs were also aware that the role was *evolving over time*, taking on new aspects of care, and blurring the boundary of the nurse and medical domains. It may be the case that the further the participants are removed from the front line, the less they are able to relate to the real-world issues being faced by the ANP workforce. The CCG commissioner comments reflect this lack of specific awareness compared with the front-line GPs:

*Local: We know that the nursing group are training and taking on new tasks all the time. GPs like to delegate don't they [laughing]. The ANPs seem to like taking on areas like triage, that kind of thing. As long as they're looked after and rewarded right then it's the natural progression of general practice, I think.*

This lack of awareness extends to the assumption that GPs are *delegating* duties to ANPs for no apparent reason other than they like to delegate. The GPs interviewed were aware that they were not delegating to ANPs but relying on them to develop their areas of expertise so as to expand their work into areas that were previously regarded as being within the medical domain. ANPs were found to be actively seeking out new areas of practice in light of a reduction in GP numbers. The commissioner appeared to assume that the duties were being delegated in a structured and organised way. In reality, and as shown in phase one, the task shifting was happening due to patient demand, reduced GP numbers and a willingness of ANPs to innovate and retrain.

The *medicalisation* of the role, as identified in the previous chapter, was discussed with the national nursing leaders. The RCN representative appeared to not be aware of the role becoming more *doctor-like* and that ANPs are increasingly replacing retired or vacant GP posts:

> *National: I wouldn't say the role is medicalised or like a doctor. Nurses are nurses and they should be proud of that. I wouldn't like to think that nurses were replacing doctors widespread in surgeries. They are part of the team. ANPs work alongside GPs. They shouldn't feel pressured to become like doctors.*

This quote assumes that ANPs are being pressured to become more doctor-like, rather than assuming a more medical-type role as a result of a natural progression required by local influencing factors. This represents a lack of awareness of the driving factors for ANP development, and how the role is *medicalising* as a result, organically, and dependent on local drivers. The NHS England nursing lead reiterated the central role that nurses play in general practice, but again questioned that the role was becoming more medicalised or that nurses were replacing GPs:

> *National: Nurses have always played a massive role in general practice. Most of the chronic disease work is done by nurses isn't it? They do a lot of extra training to be able to do all that. We're pushing general practice as a viable career option for newly qualified nurses as it's not always seemed like that. I wouldn't say nurses and ANPs are working like doctors, they should be nurses and approach the patient as a nurse. I know the ANP role is obviously diagnosing and managing conditions but there's a difference between a nurse and a GP…I'd worry about a nurse who acted like a GP, I think.*

This response recognises the contribution that nurses make to general practice, but, similarly to the RCN representative, appears unaware of the changes taking place at local level that are resulting in ANPs' work becoming more medicalised and that they consider themselves occupying a new area between the two professions. The locality workforce strategist, however, appears to be aware of the role transition and its evolution. This may be due to the fact that she is based more locally and therefore comes into contact with the workforce on a more regular basis. She also links this with the ACP role:

> *Local: Well I'm definitely aware of it. When you look at the rough figures of staff and the consultation numbers, the nurses are going up and the GP numbers are either static or reducing. More and more consultations are being done by people other than GPs like nurses, pharmacists and others. We're seeing nurses taking on more and more different roles.*

This response indicates much greater awareness of the evolution of the ANP role as the range of duties they undertake expands. There appears to be an acceptance that the role is evolving and ANPs are taking over GP consultations as a result of staff

shortages. This awareness appeared to be missing from the national leadership who were obviously more removed from the front-line. The national representatives repeatedly appear to demonstrate a misunderstanding and lack of awareness of the changes to the workforce and how the role is evolving organically.

The degree to which the role was effective in dealing with increased demand and reduced GP numbers was highlighted by the GP participants. They appear to have a conscious recognition that the general practice workforce is evolving, and have made conscious business decisions when their GP colleagues either retire or leave:

> *Local: We used to have eleven partners here and one salaried. We had one ANP at that time. We've now got 4 GP partners, one ANP partner and 3 other ANPs. We got a prescribing pharmacist as well. I think that tells you all you need to know really. I'd say we're a lot more efficient now than we used to be.*

> *Local: We've slowly built up our ANP compliment over the years. We've got 3 now and they're really good. They've kind of taken over the home visits, triage and other things. Obviously, the GPs are happy to let them do that kind of thing. Our model is an ANP kind of model with GPs as well. Over the years when a GP has retired, we've advertised for a GP and an ANP and we can then see what we get. In most cases it's been an ANP who's ended up working here.*

Without any policy or direction from central government, the GPs above appear to have recognised the problem and adapted their workforce to meet demand and changes to staffing levels. The first quote above illustrates the change in the makeup of the GP practice workforce, while the second shows the role is evolving through circumstances rather than policy. Without adaptation and role evolution, it is likely the GP post would not be filled. They accepted that the ANP role was very effective in adapting to the needs of patients and taking on new duties. The response from the GP also admits that they have adopted an "ANP model" of staffing as opposed to the traditional GP first model, highlighting the effectiveness of the role and the changing workforce dynamics. The local CCG lead nurse and clinical commissioner appear to also be aware of the effectiveness of the role, highlighting the adaptability of nurses. Rather than the GPs having no other option but to use ANPs, the commissioners recognise that ANPs have the skills to substitute for GPs in key areas. It may also be the case that commissioners, on restricted budgets, are using a lower cost alternative that, in their view, appears to be effective:

> *Local: Nurses are really adaptable aren't they. We have a walk-in-centre here that they run. We're using ANPs in a new afternoon visiting service as well where when a patient calls late in the afternoon for a visit, instead of the GP being tied up in the middle of a clinic, the community ANP can see them instead. Its working well (CCG lead nurse).*

*Local: We are seeing increased numbers of ANPs in the surgeries here. I think GPs now recognise the potential for the role and they're being used in a lot of different ways. They're part of the fabric of general practice now I'd say (Clinical commissioner).*

This section has highlighted recognition that the role is essential to current general practice. The front-line participants appear more aware than the national leaders and representatives that ANPs are adapting and becoming more medicalised in their practices, taking on more GP duties and new roles in order to meet demand. The GPs recognised the transition of the role to a more medicalised way of working and had often adapted their workforce in favour of ANPs where they were unable to recruit GPs, a factor that often appeared missing from the responses of the national nursing leadership.

### 5.4.1 Embedded

This analysis has suggested so far that not only is there a somewhat confused approach to ANP regulation within the UK, there is a lack of understanding of the changes that are happening organically at local level. Others have observed that nurses have expanded their role into what was commonly viewed as the medical domain (Nadaf, 2018; Hall, 2016). Within general practice, qualified nurses are no longer seen as the purveyors of routine tasks such as the removal of sutures, dressing changes, or receive travel vaccinations, with their GP colleagues being the sole diagnostician. Nurses are increasingly autonomous practitioners, diagnosing, treating and managing complex conditions (Nadaf 2018). The local level participants in this study illuminate how this expansion of the nurse's role is being received by GPs and how the role is now embedded within organisations, playing a key part in service provision. A GP participant described the role ANPs play in general practice:

*Local: Yes, the ANPs have a central role now with service provision. We consider them more and more when we're planning services. All the advanced roles are considered a lot more than they used to be and it'll continue to be the case, I think.*

Rather than supporting doctors, ANPs have 'a central role'. A locality workforce strategist emphasised how great the shift is that has taken place:

*Local: There's a clear direction of travel isn't there from the basic practice nurse, I don't mean that in a derogatory sense, but from the usual nurse to the ANPs now doing a lot of high-end roles. They're now partners and running practices in some cases. They've proven their worth obviously. Patients accept them and request them in a lot of cases. Where there's areas of high deprivation, with*

*practices not linked with universities or cities, then there's recruitment issues with GPs. That's where we commonly see the higher numbers of ANPs working.*

This response postulates that ANPs may be becoming equals in general practice to the GPs. This represents a major shift in the dynamics of the doctor/nurse relationship if advanced nurses are increasingly undertaking more of the previously doctor-only tasks and also take on management and partnership responsibilities. With higher numbers of ANPs working in surgeries based in deprived areas, it is commonplace for patients to regularly see ANPs only, as per the findings in phase one. The notion that ANPs are *embedded* within general practice, their roles essential to maintain effective services, and are continuing to evolve, was a factor in all the participants' responses, albeit less so from the national representatives', as with the NHS England participant:

*National: Advanced nurses are a definitely a firm fixture of general practice. General nurses are advancing as well to take on a lot of chronic disease management. There's the idea that you can have "advancing nurses" and then the ACPs doing the autonomous diagnostics and prescribing alongside nurses. So, nurses at different levels are moving into the central roles but they're still nurses and won't replace GPs.*

In the previous section, the NHS England participant expressed doubts that ANPs were taking over traditional GP roles in significant numbers, but here, after questioning on the role nurses play in general practice, she appears to now recognise that nurses were becoming a "central figure", although doesn't specifically mention ANPs. The response is vague however compared with the GPs and commissioners, who give real examples of ANPs being central to service provision and their increased use. There is also still the ongoing confusion around the advancing nurse, ANP and ACP and the boundaries of each, how they compare with each other and their scope. When considering role change and the increasingly complex nature of ANP practice, the training and development of the advanced practitioner must reflect this move to a more medicalised role. The ACP education strategist discussed the nature of ACP training and its standardisation:

*National: We now see ACP training standardisation. There's cases of HEE only providing funding for universities if they provide the same levels of training between them, instead of different types of courses. It's not universal yet though. All the different groups are trained together, and I hope the courses adapt to reflect the changes in the roles...there's always the risk that practice moves on and doesn't align any longer what's being taught. Hopefully it'll be under constant review.*

The above demonstrates an acceptance that advanced practice education is becoming standardised to accommodate multi-professions. If HEE is influencing ACP education within universities, with a push to standardisation, this could possibly risk courses

becoming more distant from what is actually needed by the workforce. If HEE lack detailed awareness of the needs of general practice, their influence on ACP education may be driving it in the wrong direction. There is also an acceptance in the response above that ANP practice may continue to evolve, outpacing the training and polices. If there is a lack of awareness of ANP evolution, it may be difficult to align the training with ANP advances. The CCG commissioner describes the issues around standardised, generalised education and how ANPs adapt once qualified:

> *Local: I suppose the problem is around a one size fits all training and it not linking with what's actually happening in practice. I know that once ANPs qualify they always go on other training courses to do more roles and work. They build on the basic training and then take on more work afterwards. In a way its like they start training and actually doing the role after they've done other training to suit their practices and patient populations. That's how they become fixed and kind of embedded within their surgeries isn't it.*

A finding from the phase one data was that ANPs were undergoing additional training to take on specialist roles such as diabetes management, minor surgery, contraceptive implants, and triage. This is reflected in the previous response. ANPs were found to be retraining in specific areas and commonly this was due to a GP retiring or leaving the practice and this role being willingly taken over by an ANP. This practice was also recognised by the CCG lead nurses:

> *Local: Yes, we're constantly putting on a lot of update days and training days for ANPs. I'm always sending out email invitations and they're always overbooked. It doesn't have to be a full training course with a qualification for them, a lot of the time they're taking on new areas, so they need to keep up to date with things and get frequent day courses.*

> *Local: I think nurses in general like retraining and learning new roles. GPs tend to qualify and then just work as GPs, don't they? We're aware that ANPs are sometimes training in other areas. We had an ANP in our area go on the minor surgery course with all the GPs and she's now doing minor ops on patients. Why not if they are trained and safe?*

These responses may indicate that local level managers/commissioners understand that ANPs are possibly taking their training and scope into their own hands, self-determining their own direction according to their organisation's and patient's needs, and despite any national policy. They may also demonstrate the reliance that the commissioners and local policy makers have on the role and how it is embedded within the local workforce dynamics. Contrast this with the view from a national level leader. When questioned on the ongoing training that ANPs are undertaking, the NHS England nursing representative admitted that they didn't have any data in this area and were not fully aware of any significant trends:

*National: Yes, I agree that ANPs train in other areas and take on specialist roles. We see that with hospital nurses and clinical nurse specialists. I'm not aware of any information at a national level on this though. If ANPs are training in specialist areas once they qualify then that's a good thing I think, it shows they're willing to keep up to date. We're not aware of any specific data though and how this changes their working roles.*

The above quote reflects a personal opinion in response to the line of questioning, rather than a response demonstrating an awareness of the issue and being based on actual data. It may also demonstrate a lack of knowledge and awareness of the underlying issue of ANPs retraining to undertake previous GP specialist areas as a result of GPs leaving or retiring, factors acutely evident in the responses of the GPs and commissioners.

A systematic review by Laurant et al. (2018) found high patient satisfaction rates for ANP consultations, little or no difference in the number of prescriptions and little or no difference in the numbers of tests and investigations ordered, or in patients' use of other services, when compared with GPs. Compare this now with the GP participants in this study as they reflected on their ANPs practice and the patient satisfaction levels with ANPs:

*Local: I can tell you that the ANPs get a lot fewer complaints than the GPs. That must say a lot about patient satisfaction. They have their own set of regular patients as well like GPs do. They manage everything themselves from start to finish so patients are well aware of what they're capable of and they accept them. They get referred to as doctors a lot as well.*

*Local: Once we started with a couple of ANPs and saw the way they worked and what they were happy undertaking, we employed two more. They all have a slightly different role, and some do triage and visits and others do a more specialist type role but all the patients like them and accept their place here. If there's any issues they come and see a GP for advice but a lot of the time they don't need it and just get on with it. When reception are booking patients I don't think they see a lot of difference between the different staff groups, they book patients in with whoever is free. Patients accept this as well and are happy to see anyone…We can't be without the ANPs really now.*

The above quotes clearly indicate the reliance on ANPs within the organisations. The GPs were aware of the high patient satisfaction levels and had employed more ANPs as a result of their performance and ability to adapt. There is also the acceptance that receptionists and patients do not usually see a difference between the ANP and GP when booking appointments, and that patients mistake them for GPs, findings evident in phase one. The response of "we can't do without the ANPs" was also reflected in the comments of the CCG lead nurses. The practice of receptionists and patients not seeing a difference between ANPs and GPs when booking appointments was also commented on by the CCG nursing leads:

*Local: Well appointments are very tight aren't they so I'm not surprised that receptionists are booking patients in with whoever they can. Patients are happy to see ANPs as well for the total management of their condition. I hear a lot from ANPs that they're seeing the exact same as a GP now, so I'm not surprised with this.*

*Local: As a nurse myself I know that patients like seeing ANPs, they get a bit longer than with a GP and I think we communicate better. Part of a nurses, kind of, nature is to explain things and relate to the patient more. Some things need a GP, but I agree that in a lot of cases the ANPs are seeing a lot more complex patients now and probably the same daily patients as a GP. For a lot less money though.*

The lead nurse responses above also appear to accept that ANPs are seeing the same patients and the same complexity as GPs, with receptionists not seeing any difference when booking appointments. If this is common practice and now accepted by GPs and commissioners, it marks a clear shift in the role of the ANP and a possible direction of travel. Despite the view that ANPs are a firm fixture of general practice and are accepted by patients as an autonomous practitioner capable of undertaking many of the traditional GP roles, their representation at a local level in health care service design and development needed further work. The CCG executive commissioner recognised the potential need for further ANP representation at the local level, considering the importance of the role to service provision:

*Local: We have a CCG lead nurse who sits on a few board level groups. She feeds the information down to practice nurses. I'd like to see more nurse representation though, and all different groups getting involved. If, like you say, ANPs are doing a lot more, training in new areas and doing a lot of the same patient care as a GP, then in the future we'll need more ANP representation.*

The above demonstrates recognition that ANPs are under-represented at a locality level despite being embedded and an important role within primary care. It is also interesting that the executive commissioner was not as familiar as the lead nurse on the issue of ANPs retraining, dealing with more complexity and taking on a medicalised role, even though they both work in a CCG environment. There is awareness that as a result of their roles evolving, they may need stronger representation in the future. There appears to be no strategy in place at present to enable this to happen that they were able to describe. The possible reasons for ANPs not being represented, and a lack of involvement in the decision making of CCGs was highlighted by the CCG lead nurse:

*Local: There may be the idea that nurses and ANPs are taken for granted that they're always there and working away, kind of thing. There's probably a lack of recognition for just how much ANPs are doing. The other side is that ANPs and nurses in general just like getting on with patient care in most cases. They're not ones to sit in board meetings and design services, they like to see patients and let someone else worry about that kind of thing. I know my role involves a lot of*

*that, but I might be the exception. I don't see patients anymore, maybe the odd agency session, but I meet with ANPs and I know they want to just see patients.*

The above response appears to suggest that ANPs merely "see patients" and don't want to get involved with strategy or service design. ANPs in this study were found to be forging their own path and adapting their practices to suit organisational needs, further emboldening their status within their organisations. This appears to be missed in the response of the CCG nurse, as she insisted that ANPs are reluctant to attend meetings, missing the changes within individual surgeries that ANPs were involved in or spearheading. There was a feeling amongst the ANPs that they were underrepresented at the local and national level, with their voice not being heard, and their practices going unnoticed. Perhaps the simple idea that ANPs want to "just see patients" is contributing to a feeling of not being represented effectively or recognised beyond their immediate colleagues.

This section suggests that although ANPs are unregulated with varying titles and practices, there is recognition at a local level that they are increasingly essential to maintain service provision and improve access. The closer to the front line an interviewee was, the more in-depth knowledge there was of the issues facing ANPs and their importance. There also appears to be a lack of ANP specific representation at the CCG level when decisions around service design and implementation are being made, although interestingly, commissioners were relying on the role to meet patient demand and GPs were using the role to fill the gaps in GP numbers.

### 5.4.2 Recognition

Recognising advanced practice, above that of a generalist practice nurse can be difficult due to the variability of the role and the unregulated scope of ANP practice. Further recognition that the ANP role is an established, embedded and credible profession within general practice was seen to be an important factor to its longevity and development amongst the ANP participants. It is possible that the lack of regulation and definitions around ANPs have contributed to a perceived lack of recognition of their contribution to general practice, not by GPs or direct managers, but the wider workforce, media, patients, and national representatives (Pearce, 2017). There was a clear concern amongst the ANP participants that their contributions to service provision were overlooked by the wider policy makers, as evident in the 2019 GP contract. The previous section highlighted the importance of ANP practice to maintaining service provision and improving access to services, but the findings of phase one suggest that

ANPs feel underappreciated and "without a national voice" when key policy decisions are being made. Bhardwa (2015) recognises this and writes that one of the main issues around the ANP workforce is the lack of recognition and understanding of what an ANP does and what they're capable of. The findings of the present study, however, show that ANPs are held in high regard by their GP employers, and their abilities are recognised by their managers, colleagues and local commissioners who are closer to the workforce. This was in contrast to the national leadership representatives who appeared removed from the evolving practices of ANPs, failing to clearly recognise their contribution, as this section will demonstrate. The CCG lead nurse also appears to be unaware that GPs and local commissioners recognise the importance of the role, its ability to adapt and innovate, and the changing nature of ANP practice:

> *Local: I know myself how hard ANPs work and how much they're willing to take on and the different roles they do, I don't think this is recognised in the CCG as it should be and in the system. There is a problem nationally and locally in recognising this and having our voice heard.*

The lead nurse recognises the problem of recognition and representation but appears powerless within the *system* to improve this. It is interesting that the lead nurse recognises the ANP contribution, but still accepts that locally, ANPs are not recognised. This presumed lack of recognition may be contributing to the sense that ANPs are underrepresented at a local level and they are taken for granted. A large survey of general practice nursing in 2012 found that the advanced roles were failing to be recognised by "the system" even though nurses were found to be innovating and moving into new areas of practice (Wild 2012). Perhaps a reliance on the ANP role and a lack of representation is contributing to the ANP sense of a lack of recognition. This possibility is discussed by the commissioner:

> *Local: There might be a reliance on the ANP, it being taken for granted. They're now in all areas aren't they, walk in centres, GPs, outpatients. It's like the silent majority just getting on with it and expanding all the time.*

Armstrong (2015) describes ANPs as being invisible within general practice, possibly due to nurses fitting seamlessly into this clinical area and just *getting on with it,* as referenced above. This was also a finding of this study amongst the phase two participants, with lead nurses and national representatives stating that ANPs wanted to mainly undertake consultations and are therefore are at risk of being overlooked in key decision making forums. This study also shows that ANPs are going much further than just undertaking consultations and "getting on with it" as the national leadership stated. The concept of the *invisible ANP* was a common area of discussion with the phase two

participants in this study, and the workforce strategist appears to agree with this concept:

> *Local: Well, as well as not knowing exactly how many are out there and what they're doing, we don't really know what they think themselves about what they're doing or what they can do. They're a bit like the unsung heroes aren't they. It seems like they're doing more and more and being factored into new services, but it's a muddled approach, I think.*

The above statement recognises that there is a lack of knowledge on what ANPs actually think about their role and its evolution, a key area of enquiry in this study. The CCG clinical director, when questioned if ANPs are formally recognised as a key member of the workforce, reaffirmed the issues around recognising the contribution that ANPs make to general practice and expressed concerns regarding the introduction of additional advanced roles without a clear scope:

> *Local: The CCG does recognise the contribution that all nurses and ANPs make, but I do agree that they're not recognised enough. We're always thinking about what ANPs can do when introducing new services or policies. There may be a case for more ANP representation when these decisions are being made rather than a normal nurse representing the locality. There's the additional issue of more ACPs coming on board and not recognising what they're doing either, they're all going to be added to the mix.*

The previous statement expresses concerns that if ANPs are not recognised sufficiently at present by local and national leaders and strategists, there may be further issues in the future with the introduction of ACP roles. There is also the acceptance of ANPs being considered when new services are implemented, although their representation is inadequate. This may indicate and corroborate the phase one findings that advanced roles are taken for granted, used as a cheaper option rather than GPs and are underrepresented in decision making. The CCG lead nurses recognised that ANPs were not always recognised for their contribution, but they struggled to provide a potential remedy for this:

> *Local: We have a have nurse representation at the CCG but that's for all community and practice nurses. There's nothing specifically for ANPs. The problem is everyone's so busy and can't attend meetings all the time. I'm not sure how we'd recognise the ANP role more within the CCG without ANPs coming forward and taking on more leadership roles.*

> *Local: I do think that I recognise how hard ANPs are working but overall in the CCG there may be a case for undertaking more workforce analysis and seeing exactly what everyone's doing and how good practice can be replicated across areas, you know, due to the variability issues. The directors and executives and board members are mostly GPs and managers though so there may be a problem with recognising fully the ANP issues and what they are capable of.*

The separate CCGs above are experiencing the same issues around recognition and representation, with the additional problem of a lack of information on the scope and practices of their ANPs. These responses demonstrate an apparent inability to increase ANP representation, and therefore recognition, within the CCGs, due to the top-heavy nature of GP and manager positions. It may represent a feeling amongst the CCG leadership and commissioners that any service design and change should come from a top down approach, and therefore include ANPs being present at service design meetings. The phase one findings show that, rather than a top down approach, service development and changes to practice were happening organically, often led by ANPs, on a practice level. The lead nurses appear at a loss as to how to recognise ANP contributions to healthcare more formally within the CCG and encourage ANPs to "come forward and take on more leadership roles". This often included the recommendation that they become involved by attending CCG meetings rather than making changes within their organisations.

The issues around the role being recognised as a viable alternative to a GP are linked with credibility. The RCN representative makes this link:

> *National: Well the issue of recognition is well known within the RCN and we work constantly to represent nurses. It's also linked with credibility isn't it. There's sometimes an issue with the medical profession not fully accepting nurses as equals or at least capable of diagnosing, managing and discharging patients. Patients see nurses as capable most of the time but other professions and sometimes other nurses themselves don't always see ANPs as independent clinicians capable of a very wide range of practices.*

The above response from the RCN lead recognises the nurse/doctor relationship and appears to relate a lack of recognition and credibility, to acceptance by the medical profession. This is in contrast to the GP and commissioner responses that are using ANPs in increasing numbers to provide services, and GPs replacing retiring GPs with ANPs, a strong indicator that GPs consider the role reliable and credible. She also highlights the issue of ANP role acceptance by other nurses, an issue also raised by the ANPs in the previous chapter. In contrast to the above, the GP participants didn't express any concerns regarding the ANPs' credibility either with their colleagues or patients. They appeared to accept the role of the ANP and its credibility, although they fail to mention that they are aware of how the ANPs perceive their role themselves:

> *Local: Well we here definitely recognise what our ANPs are capable of otherwise we wouldn't have gone down the ANP route and employed more of them. The patients love them as well. Our practice nurses as well are doing more training and showing that they can do more, so the partners here do recognise the role.*

*Local: The ANPs here are very credible in what they do, and we value them. Maybe nationally there isn't enough emphasis on the role nurses play in general practice, there's a focus on GPs even though maybe 60-70% of the clinical staff are not GPs.*

The above responses stand in contrast to that of the RCN representative when discussing GPs accepting the role and recognising its contribution to service delivery. However, the NHS England nursing representative, when discussing the issue of ANP recognition and credibility, thought that more work needed to be done, especially in light of the new multi-profession approach to advanced practice:

*National: There's plenty more work to be done to get the advanced nurse role into the public consciousness and promoted more. We're doing all we can at an NHS England level, but it also needs senior nurses to step up and get involved locally within CCGs. Nurses will be part of the ACP model and framework, so they're recognised as that, maybe though there'll need to be a lot more nursing representation and a louder voice due to the new multi-disciplinary model.*

The NHS England representative appears to accept that nurses will need a "louder voice" due to the amalgamation with ACPs, possibly an acceptance that the roles and titles will merge. Nurses being part of the ACP framework is also confusing, as shown in the previous chapter, as it brings into question the issues around titles, scope and the generalisation of the role. There is also the notion that NHS England is "doing all it can" to promote advanced nursing recognition in addition to displaying no apparent awareness that local ANPs are underrepresented in CCGs yet being used widely. With the introduction of the ACP role and allied professions joining nurses undertaking advanced roles, the future was viewed to be uncertain regarding the recognition of the role. The ACP training strategist describes her feelings on role recognition currently and in the future:

*National: I think although the role is established, it's not fully recognised by GPs and maybe commissioners as being a potential central role for improving access and when looking at services. Also, when the ACPs come into practice, nurses will be competing for the roles and need to represent themselves more. Nurses are not good at self-promotion or standing up for themselves, they just get on with it don't they. If they're alongside physios and pharmacists for example and all seen at ACPs, they'll need to adapt to that. So, I think the future is a little uncertain but ANPs have definitely proved themselves so far.*

There is recognition that the role is "established" in the above response, although an assertion that it's not fully recognised by GPs. This appears to be contradictory to what the GPs verbalised. There is also the notion that commissioners are also not fully recognising the role as being a strategy to improve access, again, seemingly at odds with the CCG director's comments of the role being increasingly considered when they're designing services. The idea that nurses will be "competing for the roles" with

ACPs is an interesting idea, and one which may be contributing to the ANP apprehension regarding the role, seen in the previous chapter, with title concerns and confusion around scope of practice. There is also the possibility the ACP role confusing the scope and domain of the ANP, a concern for the local representatives who were keen to not “upset” the system and proven effectiveness of the ANP.

This section has highlighted a gap in ANP representation at the local level within the included CCGs, although the nursing lead participants failed to recommend a strategy for rectifying this. There was the idea that ANPs needed to get involved with policy making and attend more strategy meetings to make their voices heard. This was despite ANPs demonstrating their innovative nature within their individual organisations and changing service delivery locally. There appears to be a disparity in the views of the GP participants with that of the national leadership around recognition and acceptance of the role, with the nursing leadership stating that GPs are not fully accepting of the role, contrary to the actual GP responses. The RCN and NHS England participants also thought that the role required formal recognition and linked this to an issue of credibility and acceptance from the medical profession, again in contrast to the responses of the GPs and commissioners. They also thought that ANPs themselves needed to position themselves in leadership roles and enhance the credibility and public acceptance of the role. This appears to contrast with the views of ANPs, GPs and general practice staff, who describe the role as being essential to GP services and accepted fully by the public.

## 5.5 Theme 3 – An uncertain future

Swan (2017) writes that NHS employers failed to anticipate the growth of the ANP role, and the current shortage of general nurses may be due to increasing numbers of nurses moving into advanced roles. The reduction in GP numbers had also led to greater numbers of nurses undertaking additional training in specific areas, but also more nurses taking on ANP roles, perhaps in advanced positions without the ANP title. The change in the dynamic of the workforce wasn’t foreseen by NHS employers or commissioners (Andalo, 2018). This present study shows that the ANP role and the changing nature of general practice are inextricably linked, with one influencing and being influenced by the other. This trend and what the future holds for ANPs was a key issue for the participants. It was felt that the role is undergoing significant changes, with key factors being the introduction of ACP roles and multi-professional training, the

continuing reduction in GP numbers, and the HEE framework for advanced practice. The locality workforce strategist reflected the common feeling of the participants:

> *Local: It's true that the role is changing. I think all roles change over time but as the ANP role hasn't traditionally been fully scoped out or protected, it's open to interpretation and local adaptation. The future will probably bring, and it looks like it's starting to happen now, that it'll be standardised with the ACP and the other professions. This has positives and negatives. On the plus side it'll mean proper recognition and standardisation of training and scope. On the negative it may limit innovation or maybe it might make nurse feel that they're leaving nursing and becoming and ACP only.*

The local representative accepts the risks of standardisation of practice and training; limiting innovation and adaptability, a concern expressed by the ANP participants, but seemingly rejected by the national leadership. The idea expressed by the workforce strategist, that the future ANP role, becoming an ACP, will be standardised with a clear scope appears to be uncertain, given the responses in the previous sections and from the findings from the previous chapter. There is considerable uncertainty around the direction of travel, the implementation of the HEE framework and the ongoing misuse of titles. When this point was put to the CCG lead nurse, she didn't express any clear thoughts on the future for the role within general practice and was unclear how ACPs would impact existing ANPs:

> *Local: I really don't know where the advanced roles are going. It's a bit of an experiment with the ACPs now and we'll see where it goes. I hope if it doesn't work out with physios and paramedics in general practice that they don't think ANPs are not working either, 'cause they are. I don't know how ACPs will change the ANP role though.*

This response demonstrates the uncertain future for advanced role and the unproven nature of ACPs. The lack of consideration for existing ANPs on the introduction of ACPs was also evident in the response from the NHS England representative:

> *National: There' shouldn't be an issue with other roles being brought into general practice alongside nurses. There's no threat to them. I'm not aware of any work that's being done on the impact of ACPs on existing nurses though.*

There appears to be a dismissal of any ANP concerns in the answer above. A clear statement that there are no threats to existing ANPs from the introduction of ACPs appears to be at odds with the second sentence; that they're not aware of any work being done to study the impact. The clear concerns of ANPs, commissioners and GPs were not reflected in the responses of the national representatives, highlighting a lack of communication and awareness. The ANP model, in this study, was viewed as being integral to the introduction of ACPs within general practice and was used as a

benchmark for what is possible. The HEE participant describes the policy on ACPs and how existing ANPs are anticipated to be integrated:

> *National: When considering the ACPs and how different professions can work in surgeries, the ANPs are a really good example of how it can be done. It may be the case in five to ten years that there's a series of advanced practitioners working in surgeries in various roles depending on their profession and background. I'm sure there's room for them all.*

The GP contract and HEE framework set the basis for the above multi-professional model within general practice. The long timescale for implementation runs the risk of the framework being out of date and not reflecting the pace of change within the workforce, as verbalised by the GPs. The variable roles described above may prove problematic without a clear structure and scope, especially if they're all referred to as ACPs. The issue around titles in the future remains, as demonstrated by the CCG commissioner response:

> *Local: It's welcome bringing other professions in, but we struggle now with the titles and who's doing what. I can see it getting more confusing in the future yeah, if there's physios, pharmacists, nurses and others working in advanced roles then it could get confusing. There'll have to be a lot more workforce strategy work carried out. As I've said, maybe they'll all just be called ACPs?*

This response by the lead CCG commissioner highlights the muddled approach to advanced practice. It demonstrates a lack of awareness of direction, policy, its implementation and scope of practice. The commissioner already finds it difficult to keep track of the varying titles and roles, so with the implementation of ACPs and possible ANPs being amalgamated into a combined role, he expressed concern that the situation could worsen. The ANPs pride in their nursing heritage and titles was not evident in the responses of the national leadership as they wanted to emphasise the framework for all advanced practitioners and standardisation. The issue of titles remains a contentious one. The previous assertion from national leaders that the ACP role is a level rather than a title appears not to have been made clear to the local commissioners and leaders, as the role was always referred to with the title ACP within this study.

These responses from local and national leaders in this section demonstrate an uncertain future for advanced practice with the possible amalgamation of ANPs into the broader ACP framework. There appears to be miscommunication between national and local leaders on the nature of the ACP role, the title and scope and the implementation. There is a further lack of communication evident between the leadership and ANPs. The concerns of ANPs on the future for the role appear to be dismissed by national

nursing representatives, even though they admit that they're not aware of any data on the impact of ANPs merging with ACPs.

### 5.5.1 Title confusion

ANPs in this study were protective over their nursing heritage and titles, although recognised they had abandoned many of the traditional nursing attributes. When considering the future for ANPs, they appeared concerned that their roles were being amalgamated into a broader ACP role encompassing various professions, and that their role would become more generalised and "lose the nursing element". Central to this was the issue around the title. This didn't appear to be an issue of concern for the NHS England and RCN representatives:

> *National: It's not about losing any nursing part of their role, I don't believe that is a concern. It's about standardising the scope and practice of advanced nurses. They shouldn't be worried or protective over the ANP role.*

> *National: Nurses should be nurses and we bring a lot to the role but the title or training with others isn't a problem. Change is always difficult, but I think should be embraced. Every profession has something to offer and nurses will be a part of it.*

The above may demonstrate a lack of awareness of the importance ANPs place in their titles and their nursing background. ANPs in this study were proud to act as nurses and wanted to make patients aware of their nursing background, although their evolving complex roles were becoming more medicalised, their practices moving away from the traditional nursing domain, and were routinely mistaken for doctors. The national nursing representatives appear to disregard the concerns around losing the nursing title. The exact process of ANPs possibly changing titles with the introduction of ACPs was unclear. This process was not included in the HEE Framework (2017) and the ACP wasn't intended to represent a title, however, there appears to be widespread use of ACP as a title and a concern that ANPs will have to adopt it. The GP participants expressed concerns regarding the myriad of titles around advanced practice:

> *Local: Here we obviously know who's who and what their role is as we work with them, but patients and the wider system will get confused. What's the difference between a nurse practitioner, an advanced nurse practitioner, a specialist nurse, a practice nurse, minor illness nurse….and then the other ACP type roles that are in the contract like pharmacists. It could get really messy couldn't it.*

> *Local: I think it's obvious now that patients know about ANPs and what they're doing with consultations and visits and all the other work. Most patients call*

*them ANPs as well. It could get confusing when all the others come on board but to be honest, I'll believe it when I see it.*

The previous four responses again demonstrate a lack of cohesive thinking on the issues around ANP titles between the workforce and national leadership. If employers are confused as to the titles and scope of ACPs, then patients may also be confused. The concerns around titles, as expressed by the GPs who employ ANPs, and who will be employing ACPs, are around confusion and misinterpretation of capability and scope of practice. The national representatives appear to dismiss these concerns in the previous quotes, demonstrating a disparity of views.

When discussing if a change of title from ANP to ACP would affect nurses' perceived ability to self-identify as a nurse or if it would lead to confusion amongst patients, the CCG lead nurse agreed that there could possibly be a period of confusion during any transition:

*Local: It'll probably take years for any changes to filter through and there'll inevitably be some confusion and issues. There's already some confusion about whether the ACP thing is actually a role and title or is it a level. We're not really clear. Without title protections and regulations then it'll still be the case that nurses will call themselves ANP. The confusion and problems will come from employers and patients.*

This response demonstrates the confusion around titles and the lack of advice and direction given to CCGs. There is also the idea that ANPs will simply ignore the ACP role and continue to call themselves ANP, adding to the myriad of titles and roles. The lack of awareness of the potential issues, in contrast to the previous answer, was evident in the HEE workforce representative's responses:

*National: The ACP framework is a level not a title. It's not in our ability to regulate it though. Individuals will still be free to call themselves…whatever. It might be something like ACP and then in brackets "nurse". We're not taking away any sense of who they are. I'm sure that no one should be worried or confused.*

The assertion that the ACP framework is concerned with a level of practice and not assigning a title appears to be at odds with the majority of participants in this study who all referred to the role with the title of ACP. The HEE representative also appears unaware of what pharmacists, physiotherapists and paramedics will actually call themselves when undertaking these roles stating that they will call themselves "*whatever*". This may lead to confusion amongst patients, GPs, employers and commissioners, not to mention the general public. The disparity between the ANP concerns, as demonstrated in the previous chapter and the response by the RCN

representative regarding title changes and role integration within a multi-professional framework is further evidenced below:

> *National: The framework is about standardising all professions to work at the same level. It's not about taking away titles or backgrounds. Nurses shouldn't be worried and if they are, they should read the document and get involved.*

This response assumes ANPs are not familiar with the framework or that they haven't understood it and dismisses the idea that the framework will standardise the roles, thereby limiting innovation, a clear concern of the ANP participants, GPs and commissioners. The current confusion around titles was also summarized by the CCG commissioner, who identified the difficulty in implementing a national strategy in a local context. When questioned on the framework and its strategy, he also expressed concerns regarding the period of implementation of any framework:

> *Local: We've had a lot of experience in interpreting national directives and policies to make them work locally. Any widespread changes take a long time to implement. If, as you say, there's a framework for the professions to work to, it'll take a long time as some will be under the threshold and others will be well above it, in terms of what they do. What happens to each one, do they reduce their work or retrain to build it up? I can imagine a lot of issues and it taking a long time.*

The issues around interpreting a national policy for local implementation are referred to in the previous statement. There is also scepticism in the tone, around the timescales involved and what will happen to those ANPs underperforming or over performing. There is a clear risk of generalisation of the role, limiting innovation and adaptability if all differing levels of advanced practice are standardised. A study by MacDuff (2015) found that positive interpretations of job titles can have a measurable effect on performance and employee satisfaction. A negative interpretation of a title or job description can also lead to a reduction in outcomes, productivity and performance (Holmes 2012). These issues appear to be reflected in the responses of the CCG lead nurses:

> *Local: I think probably, titles mean a lot to nurses don't they. Things like staff nurse, sister, matron, specialist nurse and ANP, they all tell you something about the level and qualification and experience of the that nurse. The worry with ACP is it doesn't really tell you about the person and their level of experience, I don't think, like are they a nurse or a pharmacist.*

> *Local: I've heard a couple of ANPs at meetings say things like "I'm a nurse so I'm not changing from ANP to ACP" and worrying about abandoning what makes them a nurse, moving to a medical type model, like associate doctors or something. There's a risk of it leading to kind of regressing to a basic role rather than the innovating that's happening now isn't there.*

These responses clearly demonstrate the confusion around ACP roles, the unclear titles and how they will be integrated with existing ANPs. The concern of ANPs that their

practices may regress to a generalised role is also evident. This section has highlighted the disparity of views on the importance of titles. The previous chapter demonstrated the ANPs' reluctance to abandon the nursing element of their titles, although the common feeling amongst the national representatives is there is "nothing to worry about". Contradictory, the local commissioners and GPs appear to reflect the ANPs' concerns, expressing a fear of introducing a new title into primary care. The HEE framework doesn't introduce any new titles, although ACP is now viewed as a title by everyone but the HEE themselves.

### 5.5.2 Boundaries

The nurse/doctor relationship, as discussed in chapter two, has evolved considerably over decades and continues to evolve. In this study, ANPs were found to be taking on increasing numbers of previous GP only duties. This wasn't a reluctant change to their role, being undertaken under pressure, but rather a willing change to improve patient care, and commonly encouraged by their managers and GP employers. These changes were also organic and dependent on local factors such as GP practice workforce changes, training and patient demand, rather than a national policy. This practice calls into question the boundaries of each profession, the scope of practice, and how this may impact patients. This section demonstrates a clear awareness of this shift amongst the participants closest to the front line, whilst the responses from the participants in senior national leadership positions appeared more reluctant to voice an opinion on the nurse/doctor blurring of professional lines and the implications. The two GP participants described the trend:

> *Local: I think it's only natural that when there's less GPs about and more patients then other roles have to fill the gaps, so to speak. It's working well though. There's a worry about how far it will go though. We're now being asked to employ pharmacists and physios and paramedics and maybe other roles. There may be a limit on how far the public are willing to go.*
>
> *Local: There's a trend towards providing primary care cheaper and with a variety of roles instead of the traditional GP model. It's ok though and seems to be working ok so far. We have ANPs here who are brilliant. They're doing more and more every year. If the staffing levels change we'd think about "do we need a GP here or could another type of role fill it".*

The above demonstrates a clear understanding of the issues. The changing demographics of the work force is evident in their responses, although they are cautious about the pace and depth of the changes, and if the public will accept widespread ANP/ACP consultations in place of a GP. There is also an acute awareness of the

untested nature of ACPs. When asked directly about the boundaries of each role and the blurring of professional lines, they accepted that there were changes over recent years:

> *Local: There's always been give and take with each role. When I was training the nurses on the ward did a lot of the nursing kind of jobs and the doctors had white coats and stethoscopes round their necks. Now it's a lot harder to split them unless there's a very specialist area. Even then there's specialist nurses doing outpatient clinics and that kind of thing. It'll only carry on with this trend with ANPs doing more and more.*

> *Local: The last few years I think has seen ANPs doing more due to the GP shortages. That's led to things merging more. We all go on the same courses and training days, have meetings together, the ANPs do a lot of the jobs I used to do, like home visits and triage and clinics. They're good at it as well. It's not like it used to be where the nurse does everything the doctor says. We have strong ANPs here so if I told them to do something in an authoritarian manner they'd tell me what to do.*

The notion of professional boundaries shifting is evident in the previous responses from GPs. There is a clear awareness of professional lines being blurred and ANPs taking on a more medicalised type of role. The first response compares the professional status of nurses with the situation twenty years ago where nurses were clearly identifiable by the uniforms they wore and their status. This response mirrors the responses of the ANPs, who recognised a more medicalised role, using the instruments of the medical profession and abandoning the traditional nursing uniform. The two roles sharing training and participating in joint meetings within practices is also a shift from the practices of the past, where nurses would have separate meetings from doctors and attend separate nursing training events. The local workforce strategist describes her thoughts on the professional boundaries:

> *Local: We don't really get involved in the type of role and if anyone's overstepping if that's what you mean…We're aware that ANPs are doing more and more but I'm not sure how they feel about it or if GPs are happy. I'm not really sure. There may be problems around patients getting confused I suppose and with more roles coming into general practice there may be a problem…*

This response appeared to demonstrate less of an understanding of the issues than the GP participants. She described the possible issues following questioning, without an awareness of specific examples. This was also reflected in the RCN lead's response to the same line of questioning around the blurring of professional boundaries:

> *National: Well nurses are bound by the code of conduct and the four pillars of advanced practice give a guide to what constitutes the level. Nurses are doing a fantastic job and the profession is recognised as being essential to improve access.*

The response from the RCN reflects the regulatory framework for nurses around the NMC code of conduct. It fails to personalise the role of the ANP in general practice and its evolution or show any awareness of the GP/ANP relationship and the blurring of professional lines. The ANP and GP recognition of the two professions having increased shared roles and scope also wasn't recognised by the national nursing lead. Kennedy et al. (2015) found that ANPs were regarded as providing a unique contribution to service delivery and were characterised by fluid role boundaries which crossed the traditional disciplinary boundaries between nursing and medicine in a study of palliative care services in a hospital setting. Hall (2016) also found that by adopting the *tools of the trade* of the medical profession, including stethoscopes, medical instruments, prescription pads, and by abandoning their traditional nursing duties and uniforms, ANPs were adopting the same working practices and styles of behaviour. It may also be the case that because the behaviours and experiences are the same, patients themselves find it difficult to distinguish the differences. The CCG lead nurse may reflect the view of patients:

> *Local: I know myself that when we have a network training afternoon for GPs and ANPs, I can't tell the difference in the room, everyone is in their own clothes and discussing medical issues and patients just the same. It's very hard to tell.*

As the boundaries of the roles become ever more blurred, there are some difficulties with these changes. Professional identity and scope come into play, with a perception that their own practice is under threat. The CCG commissioner appeared to reflect this notion:

> *Local: I know from speaking to GP colleagues that this is an assumption and maybe a worry that these roles expanding more and more is putting the GP profession at risk. If there's a role for home visits and a role for left for the GP…that kind of thinking.*

This quote demonstrates a concern regarding the encroachment of the ANP into the medical domain. It appears that this concern is limited though, as GPs employ more ANPs and they undertake more tasks previously undertaken by doctors. The concern that GPs will be replaced widespread by ANPs and ACPs is also reflected in the NHS England representative's comments although she didn't consider this a problem as the two professions were seen to be distinct from each other:

> *National: Nurses approach patients in a different way to GPs. That's not to say GPs are doing anything wrong but the professions are different and manage patients in their own way. ANPs are very skilled and their scope is large but they practice according to their experience and training and qualifications. Patients like consulting with nurses don't they, the communication is often different.*

The above response once again appears to miss the point of professional lines being blurred, instead reflecting on the NMC code of conduct and ANPs working in line with their qualifications and experience. The ANP recognition that the role was possibly a hybrid of the two professions and encroaching on the medical domain wasn't commented on by the national nursing lead, instead stating that patients enjoy consulting with nurses due to the different communication styles, rather than for their medicalised role. The concept of the ANP's appearance, practice and demeanour reflecting that of a GP wasn't commented on by the national nursing leadership and appeared to be a concept they were unaware of.

This section demonstrates a distinct disparity of views between the GPs and the national leaders. Nursing representatives were either dismissive of the ANP role becoming medicalised and nurses adopting a doctor-type persona, or they didn't appear to grasp the concept. The GPs and commissioners expressed concerns regarding the possible widespread replacement of GPs by ACPs in the future although they valued their current ANPs who were carrying out increasingly complex roles.

## 5.6 Summary

The thematic analysis of the phase two interview data resulted in three themes emerging*: strategy, an essential role*, and *an uncertain future*. There appears to be a disparity in the views of national representatives, with those closer to the workforce. These differences are concerned with the changes to the ANP role, incoming ACPs, and the medicalisation of ANPs. The national leadership did not appear to recognise these changes or relate to it, whilst the GPs and CCG leads clearly indicated that the ANP workforce is adapting to take on new challenges. All the participants recognised the contribution that ANPs are making to general practice, with the GPs particularly aware of the ANP role when considering any workforce changes. They did express concern that the GP role and boundaries are being encroached on by advanced roles, but also accepted that they rely on them to provide essential services.

The issues around the myriad of titles of advanced practitioners and the incoming ACP role was concerning to the CCG and GP participants but was repeatedly dismissed by the national representatives, indicating a possible inconsistency in the approach. There also appears to be ineffective communication between the national bodies and the CCGs and GP practices around the ACP roles and the recent framework, how this will

be implemented, governed and regulated, and how these new roles will fit with the existing and established ANP.

The concept of the nurse-doctor professional boundary was an interesting discussion area. Again, the national leadership appeared more removed from the awareness shown by the GPs and commissioners on the ANP role and its move from a nursing model to a possible hybrid model incorporating many aspects of the medical approach to care.

All the participants viewed the ANP as an essential role in the makeup of the general practice workforce. As this workforce evolves, so too does the ANP. This was recognised by the CCG, workforce strategist and GP participants. The responses of the national leaders indicate a possible lack of awareness of the ANP's evolution and its increasing adoption of traditional GP duties.

# Chapter 6

# Discussion and Limitations

## 6.1 Introduction

The aims of this study were: to explore, compare and contrast the views of ANPs, managers, NHS leaders, commissioners and employers with respect to the current and evolving role of the ANP in general practice; to develop a new understanding of current ANP practice; and to make policy and workforce recommendations. It makes an original contribution to knowledge in an area where research is lacking – the current nature of the ANP role in general practice as experienced by front-line practitioners, the direction the role is taking, and its utilisation by managers, commissioners and employers during a period of financial restrictions and reduction in GP numbers. This chapter summarises the study findings, explores the new insights they offer into ANPs working within general practice, and discusses implications for policy and the wider workforce.

This study has shown that ANPs are increasingly taking on extended duties, retraining and being utilised in what were previously doctor-only roles. ANPs now perceive their role as more of a hybrid medicalised role, rather than one of purely nursing. This concept was somewhat recognised by the local representatives but appeared alien to the national leadership. As the role evolves, it is increasingly being used by commissioners and GPs to fill gaps in service provision, a process about which the ANPs were enthused. Multiple contrasting views existed between local policymakers, ANPs and the national leadership. The national strategy for advanced practice was shown to be confusing, disjointed and ineffectively communicated to the local representatives, and seemed distant from developments that are happening in practice. At the local level, in contrast, there were differing views and even a lack of knowledge among ANPs and local policymakers about what is happening at a national level regarding ANPs, titles, scope of practice and the ACP implementation. Areas of concern for ANPs included the introduction of ACPs, the multitude of titles, a framework for all advanced practitioners, and how these changes will impact the identity of the ANP and its ability to adapt to local pressures.

In the discussion that follows, the two phases of the study will be amalgamated and explored through the overarching concepts that link the two phases: *identity*, *the ANP as the agent of change,* and *the paradox of advanced practice.*

## 6.2 Identity

Identity is one's self-concept based on attributes, beliefs, values, motives and experiences (Ibarra, 1999). Professional identity is not simply formed by the profession in question; it is influenced by official recognition, related professions, public opinion, scientific developments and economics (Wackerhausen, 2009). Developing a strong, coherent identity is essential to structure the roles of professions and provide a framework within which the expectations of society are created and managed (Monrouxe, 2010). The personal identity of ANPs and where they fit within the professionals' domains of practice was found in this study to be evolving. They remained professionals, saw themselves as nurses, but questioned their stance within the nursing and medical spheres.

Professionalism refers to a workforce whose members are self-governing rather than subject to hierarchical or managerial control, have a shared identity and ethical standpoint, and seek to protect jurisdictional boundaries and demarcate spheres of practice in relation to other groups (Evetts, 2013). Although nursing is widely agreed to be a profession (Ghadirian et al., 2014), it is in some ways distinct from other professions in that its members are subject to hierarchical control through a clear structure of grades, banding, uniforms and titles, all of which demarcate one aspect of the profession from the other and allocate tasks and responsibilities accordingly. In a GP practice, the professional nurse is not immediately distinguishable from doctors, because the identifiable white coat of the doctor and the nurse's various uniform colours are abandoned. ANPs adopt many identifiable signifiers of the GP, such as smart formal clothing and diagnostic equipment. The two professions, this study shows, undertake many of the same duties. The general practice based ANP therefore can be argued to bridge the nursing and medical domains and occupy a hybrid role. However, this study has demonstrated that as the distinction between ANPs and GPs is becoming more fluid, a greater distinction between ANPs and other nurses appears to be evolving. ANPs recognise that their identity is separate from that of a general nurse due to their training, knowledge, behaviour, and status.

This finding is the first of this study's unique contributions to the literature. ANPs exemplify theories of the *third space* profession, or the 'boundary zone' where two cultures meet, hybrid identities take shape, and new discourses are created (Verbaan and Cox, 2014). Their transition from caregiver to care prescriber, and the delegating to other nurses of nursing tasks that they themselves no longer perform, was recognised by the ANP participants as indicators that they were something other than a nurse.

Chulach and Gagnon (2015) described the phenomenon that takes place when different workplace cultures come into contact. In this space, identities are reconstructed, existing cultural relations are transformed, and new boundaries are created (English, 2005). Occupations within this third space often combine aspects of both cultures to create a new and unique role (Jacobs and Brandt, 2012). This was found to be the case with the ANP participants in this study. In contrast, the national leadership asserted that ANPs were still wholly based within the nursing realm.

Knowledge acquisition, used as a commodity, is a highly prized possession within a group (Cruess et al., 2009). Medical students and doctors demonstrate a strong sense of shared identity and kinship, relying on evidence-based practice to enhance their professional identity (Ware, 2008). The medical profession was historically resistant to the delegation of tasks from doctors to nurses (Tye and Ross, 2000), but now accepts the ANP role and recognises its adaptability and effectiveness (Nadaf, 2018). This study builds on this knowledge by demonstrating that rather than GPs delegating their unwanted duties to ANPs, they were delegating many aspects of their own medical role out of necessity. Advanced nurses were willing to undertake these roles, retraining to carry them out, and were often the driving force behind these changes. This study also demonstrated that the ANP role is increasingly considered by commissioners and managers when designing service provision, often in place of GPs. This represents an important shift in the dynamics of primary care, where the GP may no longer be the central role in general practice as ANPs advance and transition towards the medical domain.

Increased knowledge results in increased power and status. The additional diagnostic and medical knowledge obtained by ANPs has been argued to set them apart from the general nursing profession, leading to their own sense of unique identity, distinct from general nurses and more aligned to the medical profession (English, 2000). However, this new identity was not so sharply defined in the present study, as although ANPs no longer considered their role purely nursing they were hesitant to consider themselves anything other than a nurse. When professionals lack a sense of belonging, it can impact their identity (Chulach and Gagnon, 2015). ANPs were aware that they were forming their own distinct identity, but this was incomplete and not yet unique. When hybrid practitioners are not seen as unique, their practice may become ‘essentialised’, according to Rashotte and Jenson (2010). This results in ANPs being classed as either part of the nursing domain or part of the medical domain, rather than practitioners in their own right, occupying a unique space between the two areas of practice. They lack a coherent distinct identity, cling to an old identity that they do not want to abandon, but

at the same time, they want to forge a new uniqueness as their role evolves. They are trying to hold two contradictory positions at the same time, while they are in this liminal space between the old and new identities. This study theorises that ANPs in general practice are in the course of transition, perhaps to a third-space profession, although the ultimate destination is unclear at present. This has implications for the future regulation, protections and development of ANPs and ACPs. They are currently registered and identified, grouped by their individual professions, to their governing bodies. If all newly qualified advanced practitioners (including ANPs) are to use the unintended ACP title, as appears to be the case, then this sets them apart from their generalist colleagues in their respective professions, and may give them a new identity, possibly without an immediately identifiable indication of their background profession. How the newly qualified ACPs identify themselves compared with their ANP colleagues is unclear and has implications for self-identity.

This study has shown that there is confusion and uncertainty around these areas from the national leadership. The ACP title is an unintended consequence of the HEE framework and it remains to be seen if this will be adopted by nurses already working in advanced roles, or whether yet another advanced title will only add to the confusion around identity, scope and boundaries. Perhaps a distinct ACP register, separate from the individual governing bodies, would aid with a new identity, although this appears to be unlikely with a disjointed and confused approach to regulation amongst the nursing leadership and with experienced ANPs showing no indication that they will change their titles, as demonstrated in this study.

The formal masters-level education of ANPs is arguably based on the medical model of history taking, examination, provisional diagnosis, investigation ordering, result interpretation and differential diagnosis, with little mention of the traditional aspects of nursing: the nurse–patient relationship, communication, teamwork and holistic care (Anderson, 2017). The follow on, ad-hoc training ANPs were found to be undertaking to fill the gaps in service provision is also based on the medical model. This study found that ANPs are innovating and adapting their role post qualification and were retraining to enhance their abilities, but their initial advanced role education may represent the first step in the ANP's transition to a more medicalised way of working. This new knowledge and training created a sense of *belonging* to a group of ANPs who are gaining knowledge seemingly unavailable to general nurses and more in line with the medical profession, but yet still uncertain of their identity. This elevated level of knowledge and practice was found to set them apart from nurses but, as noted above, stranded them between the two professions. Their formed, linked identity with other ANPs, rather than

general nurses, was evident in this study and began during their ANP education. They dismissed any general nurse who was undertaking a minor illness role as 'not being a true ANP' – interestingly, in the same manner that the medical profession has been accused of adopting with ANPs, referring to them as 'noctors' (not-doctors; Coombes, 2008). These protectionist behaviours of forging their own territory, transitioning to a new scope of practice and developing a hybrid role, evident in this study, highlights how ill-defined is the process of transition to a new professional identity. It appears to begin with ANPs becoming aware that their roles are unique and *separate* from a nurse, leading to their adopting new practices, then retraining to fill in the gaps in service provision that are varied and unpredictable as they arise because of local pressure, and then these practices becoming established and recognised by local commissioners and managers. These innovative and new roles were placing them in an undefined and as yet untitled 'third space' area between the nursing and medical professions.

In this 'third space' there is little to distinguish ANPs from general practitioners. Various authors have observed this, arguing that it is increasingly difficult to differentiate the ANP's expanded role from other biomedical, cure-orientated identities such as medicine (Nielson, 1999; McClellan et al., 2014). This study expands on these authors' work by comparing and contrasting the perceptions of ANPs themselves, that is, it explores how ANPs themselves are experiencing this transition. As the ANPs in this study progressed with their careers, the adoption of the medical model was more evident in their responses and experiences as their roles expanded and they retrained to take on new tasks. Consequently, the types of patients they managed became more complex. Their perception of their own identity and status was transitioning to a more medical identity, and they were often adopting the behaviours and phrases used by doctors. This was observed by both ANPs and regional or local-level policymakers who interacted with them. For example, one regional-level phase two participant reported that she had observed ANPs in training events and meetings with GPs and could not tell any difference between the two groups; the abandonment of the nursing uniform being a key factor in their transitional identity, and the influx of women into medicine in the past 30 years changing the traditional male GP/female nurse dynamic (Jefferson et al., 2015).

ANPs in this study reported that both patients and other medical staff were routinely mistaking them for GPs. This caused them concern: they did not want to be seen to be abandoning their nursing heritage and not be recognisable as nurses. At the same time the elevated status of being mistaken for a doctor and the recognition this brings were seen to validate their worth and distinct identity. These paradoxical feelings have been

found in research examining role transition. Transitions are often accompanied by emotional turmoil, as individuals struggle to redefine themselves and adjust and adapt to new life circumstance (Gill & Shanta, 2019). The Bridges & Mitchell (2000) transition model describes three stages of change when a person is transitioning to a new role. These are *a)* ending, losing, and letting go, *b)* the neutral zone, *c)* new beginning. During this period between the old reality and the new one, individuals learn to handle the consequences, with psychological shifts taking place, and it is in the neutral zone stage that individuals create a new sense of identity (Bridges & Mitchell, 2000). The ANPs in this study appear to be in Bridges' & Mitchell's neutral zone or third space, forging their new identity, although this study provides insight to how anxiety-filled is the transition, how there is resentment to others outside the neutral zone, and concerns about the confusion felt by themselves and others around their status (op cit, 2000).

This confusion was exemplified in their discussions of the introduction of allied health professions to advanced practice. This was welcomed in some ways by ANPs, although they were concerned about a framework that aimed to cover all professions, irrespective of professional background. ANPs in this study gave examples of nurses, physiotherapists and pharmacists being told to 'leave their profession at the door' during ACP training, and then referring to themselves as ACPs once qualified, demonstrating a possible shift to a new identity and status. This created confusion around ANPs' own identity, concern about no longer belonging to a specific profession, and anxieties around losing the nursing element of advanced practice, although they were already aware that many of their traditional nursing skills were being devolved to general nurses in order for the adoption of a more medical type role. ANPs in this study felt that if all advanced practitioners were to be referred to as generic ACPs, as appears to be the case in practice, it would call into question whether the specific professional background of the individual matters at all. It is perhaps to be expected that whilst ANPs are carving out their new identity and scope, they would be resistant to an alternative new title and perceived identity being imposed upon them during their transition (Bridges & Mitchell, 2000). If, as this study shows, ANPs value and want to protect their nursing background, but are aware that they are transitioning to a new space whilst being reluctant to adopt a generalist ACP model, then current strategies for introducing the ACP role alongside existing ANPs, in line with the HEE framework (2017), may face resistance. The confusion around these advanced roles, backgrounds and titles further adds to the questions around the identity of ANPs. In other words, on the one hand, they are nurses, proud to be nurses and very loyal to the profession of nursing. On the other hand, they are experiencing a transition to a medical model, altering their self-

perception, blurring professional lines, yet relishing the opportunities of the collapse of the distinction between general medical practitioners and advanced nursing. These contradictory positions further complicate their identity and boundaries; one that is neither purely caring nor curing, but a combination of the two.

### 6.2.1 Professional boundaries

The process of task-shifting from GPs to ANPs was evidenced by multiple examples in this study, largely due to patient demand, reduced GP numbers, and the ANPs' personal drive and ambitions. This process was found to be organic, dependent on local influences, and not as a result of any formal local or national policy. The commissioners and GPs were aware of this phenomenon and often considered the ANP when commissioning services. As a result of these innovations, the boundaries of the nursing and medical professions were breaking down within the organisations involved in this study. This was evident in the ANP and GP accounts of receptionists not seeing a difference between a GP and ANP appointment although recognising a clear distinction between ANPs and general practice nurses. Advanced practice is difficult to define (Stasa et al., 2014), and the scope and boundary of the ANP is fluid, although those on the ground, such as the GPs and receptionists, may recognise the scope of the role more easily. This present study has shown that this fluidity has a positive effect at local level on the ability to innovate, retrain and develop new services.

There is however a distinct contrast between the local and national perspectives representatives on the ANP role; in highlighting this disjuncture this study offers a unique contribution to knowledge. The national leadership viewed the ANP as a nursing role with clear boundaries and largely distinct from the GP role. The concept of a fluid boundary and the ANP stepping into the medical domain was not recognised by the nursing leaders and strategists. They questioned the blurring of nursing and medical boundaries and insisted that the role was purely that of a nurse and bound by the NMC code of conduct. This is contrary to the views and experiences of ANPs. If the national framework and future regulations limit this fluidity of boundaries and hinder innovation and adaptability, this could have an impact on the functioning of the general practice workforce which is increasingly reliant on advanced roles. Although the HEE framework is used as a basis for ACP education at universities, it has no regulatory powers at present over the practices of qualified ACP/ANPs. It is unclear how it could become a mandatory framework without formal regulatory powers, a register, and a new Act of Parliament. The possible implications of ANPs rejecting or ignoring a national

mandatory structure and scope are also unclear. As the ANP transitions to a new identity, between medicine and nursing, it leads to the question of what would happen if this was recognised by the national leadership who at present show little appreciation for these changes. They may seek to impose new regulations on the role to ground it more firmly in the nursing sphere and within their powers of influence. It may also be the case that this transition is too far advanced to revert back to a generalised advanced nursing role. The RCN, NMC and HEE currently have very little impact on the ANP's practice and transitioning role, this study suggests, so perhaps their influence has already diminished too much to be reinstated, unless without major rethinking on the part of the national bodies.

These concerns were voiced by the ANPs themselves and the local representatives. In contrast the HEE Framework for Advanced Practice (2017) was promoted by the national leadership as a guide for the level at which ANPs should be practising. Not only did all the ANPs in this study far exceed the level recommended, but also all ANP participants were largely unfamiliar with the guide, questioning its relevance to their current and evolving practice. In addition to their questioning of the HEE framework, they outright rejected the voluntary RCN credentialing scheme and viewed it as unnecessary and superfluous. This study has shown that ANPs had discarded routine nursing tasks such as blood samples, dressings and routine assessments in favour of more medicalised duties such as triage, acute home visits, diagnostics, and specialist clinics. As the ANP/ACP role evolves over time and increasingly blurs the boundaries of the nursing and medical professions, it may become evident that the ACP training and framework is already outdated and no longer meets the requirements of general practice. If the current trend of decreasing GP numbers, increased demand, and an increasingly medicalised ANP role continues, it may be that a standardised, generalised multi-profession ACP role is insufficient in place of the innovative, adaptable and fluid ANP role shown in this study.

Previous studies have shown how the medical profession has demarcated 'exclusion' areas that only they can operate within, identifying tasks only they can carry out, and marking out their exclusive territory (Witz, 1992). This present study suggests change is occurring, as it demonstrates a clear move away from this practice, with GPs, commissioners and managers keen to use ANPs in service provision, recognising their abilities and often allowing the ANP to undertake previously GP-only duties. The GP participants expressed some veiled concerns that their numbers were reducing, and that advanced allied professional roles were being promoted, but ultimately welcomed ANPs, with no apparent overt protectionist behaviours over aspects of their own role.

When the national nursing leadership were questioned on the blurring of professional lines and ANPs sharing many of the responsibilities of GPs, their answers were vague and not appreciative of the issue, demonstrating a clear disparity of views and a lack of appreciation for the reality of general practice workforce changes. This study has shown that the traditional conservative medical profession, protective of their boundaries, defensive of medical tasks and duties, appears to be moving towards a situation of shared responsibility for the medical care of patients. This is further evidenced by the 2020 GP contract, negotiated by the BMA and RGCP, which provides funding for a variety of ACP roles working within general practice and the responsibilities for undertaking home visits, acute appointments, triage and medication reviews being largely transferred to ANPs and ACPs (referring to ACP as a title). It may be the case that the medical profession has little control over this process of change, as demand and the declining number of GPs has forced their hand. These additional roles were largely not in post at the time of writing and are experiencing recruitment problems (Legorien, 2020). ANPs are adapting, transitioning, advancing, and filling in the gaps in the meantime, as recognised by the local GPs and commissioners.

### 6.2.2 The lure of advancement

Styles (2005) used the term ‘profession-building’ when describing nursing’s struggle to achieve recognition as a profession, with enhanced knowledge being one of the key attributes on this journey. As nursing has become a degree-graduate profession, with ANPs obtaining master’s degrees, this enhanced knowledge sets nurses today apart from the previous vocational, caring role. However, Gray (2017) asserts that nursing still occupies a grey area between vocation and profession with skills such as communication, caring, kindness and compassion being held above a medicalised, technical and curative skillset. These traditional traits were also held as key nursing attributes by the national nursing and leadership participants in this study. In contrast the ANPs did not consider their roles as a vocation; they were highly educated and were keen to be recognised as independent practitioners, relying on their medicalised training and knowledge more than their traditional nursing attributes. Despite nurses educated to degree and master’s level, undertaking specialist roles, and advancing their practice, the notion of nursing as a calling and a vocation is still debated in the literature (Quinn, 2017).

The route nursing has taken, moving towards an autonomous professional status, separate from but equal to medicine (Allen, 2007), is perhaps epitomised by the ANP

role; an autonomous practitioner, undertaking many of the traditional GP duties, capable of innovating and adapting to local demands. However, this study shows the unexpected consequences of such a movement. That is, ANPs were eager to modify their nursing status, take on new duties and further *medicalise* their practices, and these changes were moving them away from a traditional nursing role and status. The desire to achieve even greater autonomy, recognition and higher status, with enhanced knowledge and skills, sets them apart from general nurses and arguably moves them into a new hybrid profession, distinct from the perceived caring, empathetic nurse, and more in line with a medical role. This is not to say that ANPs are less empathetic or caring than their general nurse or medical colleagues, but rather their behaviours, practices and self-identification were seen as different to that of a nurse, a change participants felt was recognised by patients. As the ANPs in this study described themselves as undertaking largely the same role as a GP, and aligned themselves with their medical rather than nursing colleagues when discussing training, meetings, and practices,, they are recognising their elevated status and defining themselves as equals with the medical profession, although not in the way anticipated by Allen (2007) because of the distinction that is emerging between ANPs and other nurses. This is a concept not recognised by the national nursing representatives. This elevated status, alignment with doctors, and change to their self-identity may be a strong lure for general nurses to advance their roles.

This study has shown that ANPs are eager to medicalise their roles and seemingly happy to accept task-shifting from doctors and also pursue these additional duties themselves, building on these adopted tasks to develop a new area of practice, influenced by their nursing background but yet abandoning many of the traditional nursing traits. This raises the question of why ANPs are accepting of a more medicalised role. There is undoubtedly a move towards a more fluid and dynamic workforce in primary care, one where not only GPs, but multiple professions undertake assessments and consultations (NHS Digital, 2019). However, this study has shown this move to be confused, variable, and disjointed, with ANPs making this increasingly complex transition largely without direction or an influencing policy. As medical practice becomes more technical, scientific, and efficiency-driven, nurses are adapting by also becoming a more advanced profession, focusing on technical and medical tasks (Porter-O'Grady, 2014). With the introduction of nursing apprentices, associate nurses, and additional task-shifting from general nurses to associates and healthcare assistants (HCA), it may be a natural evolution for nurses to want to advance their own status to distinguish themselves from these lower grades. If the direction of travel is one of

general nurses becoming more technical and advanced, and ANPs transitioning to a medicalised hybrid role, it may be that the majority of the traditional nursing duties will be carried out by HCAs and nursing associates. Registered nurses and advanced level nurses may be distinguishing themselves from these unqualified roles, which are growing in numbers, by advancing their practices and moving into the medical domain. In the same way that a shortage of GPs may be one of the driving forces behind the ANP's role transition, a shortage of ward nurses may be the driver behind the introduction of 'advanced' HCAs and nursing associates. Interestingly, the RCN have previously warned of the risk to patients by the shifting of work from qualified nurses to HCAs (Sulehria, 2015), in a way they have not done with the task shifting from GPs to ANPs, as demonstrated in this study.

Being an ANP was not seen as simply accepting tasks from doctors and carrying them out, it was the utilisation of the skills of the experienced nurse and bringing them to their new role, combining nursing and medical knowledge to improve patient care, adapting and innovating, bringing a nursing perspective to a new medicalised role. A profession should stand alone and demonstrate unique knowledge (Allen, 2007), and the ANPs were demonstrating this concept rather than simply accepting unwanted tasks from GPs. Their nursing knowledge undoubtedly aided them in their transition to a third space between the two professions, but they relied on their medical knowledge, ANP training, and additional supplementary education much more substantially than their original nurse education, viewing their nursing skills as valuable but less essential than their medical knowledge. They recognised this adaptation and viewed it as a natural transition in order to undertake the evolving role more effectively.

Social identity theory (Tajfel and Turner, 1979) is based on the principle that individuals strive to maintain or enhance their self-esteem, striving for higher status and a positive self-concept. This theory also asserts that groups are separated through social categorisation: an *in-group (us)*, and an *out-group (them)*. ANPs in this study were transitioning away from the nursing model, demonstrating a social identity more in line with their GP colleagues. This was a result of their new practices and may be a strong lure for general nurses towards advancement if the medical profession is still seen as superior (Leary, 2019). They also established an *out-group:* nurses who they viewed as being an unqualified ANP but yet were using one of the various advanced titles. They held negative attitudes to these *out-group* members. This demonstrated an aspect of social identity theory: portraying negative aspects of the out-group to enhance one's self-esteem (Tajfel and Turner, 1979). This negativity towards general nurses acting as ANPs without formal qualification also demonstrates awareness that their role and

status is distinct and separated from general nurses, occupying a third space. It may provide another tempting lure towards advancement and the undertaking of medicalised duties if this transition positions the nurse within the *in-group* of ANPs. In this they may be resistant towards the national leadership who, in appearing to view the role as largely nursing with bolted on examination and prescribing skills, suggests a lower status than that which ANPs are claiming. This represents a disparity of views between the two groups, which has implications for a national strategy for advanced practice. If the role transition is not recognised by the nursing leaders and policymakers, it may indicate that ANPs are developing their role organically and acting as *change-agents*.

## 6.3 The ANP as an agent of change

A change agent is anyone who has the skill and power to stimulate, facilitate and coordinate the change effort (Lunenburg, 2010). ANPs may be acting in an unintended change agent role, demonstrating their ability to adapt and innovate, thereby changing the workforce dynamics, not only in general practice but within the wider healthcare setting. Maier and Aiken (2016) write that global drivers to increase efficiency and reduce costs, in addition to a shortage of GPs, are possibly influencing nurses to accept the shifting of tasks from doctors to nurses and promote their own careers. This study contrasts previous studies by demonstrating that ANPs are not simply accepting tasks as a result of GP shortages, but rather directing the change themselves, innovating, and filling in the gaps in service provision, acting as the agent of change rather than the recipient. Several national policy initiatives have undoubtedly paved the way for advanced roles and the shifting of duties from doctors to nurses (The New Deal, 1991; UKCC Scope of Professional Practice, 1992). However, these early policies are less relevant in the modern healthcare workforce. This study demonstrated that ANPs are innovating and expanding their practice, without local or national policy drivers and the process was organic and dependent on local pressures. These changes were also effective and recognised by the commissioners and managers following ANPs trialling the changes and then rolling them out within their organisations. There appears to be an evolution in the process of service design; ANPs push the boundaries of their scope of practice, innovate and retrain, and then this practice is adopted more widely by the local commissioners and employers. In addition, the commissioners were keen to utilise the role when introducing new services and ‘filling in the gaps’, demonstrating an awareness of the potential of the role and its ability to instigate change. The adoption of new practices and the embracing of advanced practices unique to their organisations

further separated them from their general nursing colleagues who were viewed as a more stable, generalised role, utilising a task orientated approach.

As ANPs appeared to be acting as their own change-agents, they were transitioning to a new identity; one that was of their own determining. This wasn't unconscious or involuntary, but with purpose and confidence, albeit that there was some hesitation about it. They were aware of the role transition and were actively pursuing it, retraining, adapting and innovating, in order to both enhance their own status, careers and positions, and improve patient care. The single-mindedness and independent thinking of ANPs was evident in this study as they relished the opportunities they were given to innovate. Boucher et al. (2015) asserted that ANPs are in a central position to both initiate and ensure optimal adherence to best practices and care processes, often changing these processes by influencing and fine-tuning care delivery. This present study goes much further than fine-tuning care delivery and influencing care processes, as the ANP participants were the driving force behind the changes not the unwitting participants – this represents a unique contribution to knowledge. ANPs were actively seeking new areas of practice, demonstrating they were effective, and then seeking widespread adoption of these roles within their localities. These changes were in conjunction with local commissioners' approvals and their acceptance of the role and its ability to enhance service provision.

### 6.3.1 A leadership lacking control

This study highlights the national leadership and policymaker desires to ensure a standardised level of both advanced practice and ACP multidisciplinary education. This is a step in the right direction in terms of reducing the numbers of nurses' and other allied professions working as advanced practitioners without the necessary qualifications. However, several issues exist with the current limited approach. The first is that the HEE Framework (2017) is voluntary and is shown in this study to be largely misunderstood by the workforce and local commissioners and has not been communicated effectively to ANPs. There are also concerns around a framework which was seen to possibly hinder innovation and adaptability. Studies have shown that a fluid scope of practice, unhindered by boundary definitions, aids both innovation and the ANP's ability to take on new roles (McGee, 2009). The risk of advanced roles becoming generalised and 'all at the same level' is a valid concern amongst the participants as this was viewed as a hindrance to adaptability. This study has shown that ANPs are adapting their practices to suit local demands and pressures and this would possibly be

negatively affected by a framework that is seen to restrict the expansion of their roles and doesn't allow for the transition to a hybrid role status. The framework also does not attempt to limit the use of the titles for advanced practitioners. In fact, it is widely seen to have inadvertently introduced the ACP title into the vocabulary around advanced practitioners. All the participants in this study referred to allied professions in advanced roles as ACPs, without clear knowledge of where the title originated from. It may be the case that in the future, all nurses and allied professions in advanced roles will refer to themselves as ACPs irrespective of their background, and these roles will be classed as a hybrid-medical role, distinct from their original professions. This process may be in its infancy with the adoption of multi-profession advanced training and the unintended ACP title and it may be that ANPs are the first professional group working at an advanced level to begin the transition to a third-space, to be followed in time by physiotherapists, pharmacists and paramedics. This may be inadvertently hindered however if all the roles become generalised, working at a level below current ANP practices.

How the HEE framework fits with the unrelated RCN credentialing scheme is also unclear. The HEE framework is directed mostly at universities training varied professions, whilst the RCN credentialing scheme is aimed solely at nurses and costs approximately £270 every three years. It is questionable why nurses graduating with an ACP master's degree would then undertake the voluntary credentialing scheme from the RCN which wouldn't change their status, title or income. This was indeed commented on by the participants as they questioned the usefulness of multiple frameworks and guidelines to their daily work. ANPs ultimately continued to make the transition to a new area of practice, seemingly with no regard to these policies.

Leadership is one of the four pillars of advanced practice (HEE, 2017; RCN, 2019). Interestingly, the ANPs in this study did not consider themselves leaders, managing a large team, designing policy and services, or acting as a figurehead within their localities. However, they were displaying leadership qualities and a quiet confidence that they could innovate and improve services through their own abilities and those of other ANPs. One group of ANPs had redesigned the end-of-life care service for a large area of patients, taking the GP out of the service provision and redesigning the community services provided. This had been recognised by their CCG and was being considered as a wider service to be implemented in the district. Another ANP was instigating a widespread care home visiting service, regular 'ward rounds' and urgent triage for care home staff. Again, this was done to eliminate or drastically reduce the GP's involvement. Although none of the ANPs were in a leadership position in the traditional sense of the word, they were displaying leadership qualities by redesigning

local services around their roles and abilities. Previous studies have shown that for nurses to be effective leaders, they require strong organisational support to improve patient care and outcomes (Kennedy et al., 2012). This was shown to be lacking with nurse consultants and clinical specialists based within hospitals (Rosser et al., 2017). The ANPs in this present study were fully supported by their employers, retraining to adopt new roles, and recognised by the commissioners as an effective workforce. As they viewed their changing status as being distinct from general nurses and transitioning to a hybrid role, they were supported and encouraged by their managers and employers during this process.

The national leadership appeared to equate leadership with attending CCG meetings and locality workforce strategy events, rather than recognising a new area of practice, and adapting their own status, duties and roles to meet local pressures. When asked about ANPs feeling that their leaders were not in touch with the changing workforce, or that they were underrepresented, the nursing policymakers responded by advising that ANPs should become more involved with meetings and conferences, and keep up to date with the latest national nursing policies. The changes ANPs were implementing, showing clear leadership, ambition and drive within their organisations, represents a clear form of leadership, not recognised by the national nursing representatives.

The findings of this study indicate that the national leadership are attempting to define the ANP role by providing a framework for practice, which is possibly being ignored by the workforce and the local employers and commissioners. The framework risks becoming out of touch with practice and not reflecting the evolution and transition of the role towards the occupation of a third space. This is evident in the contrasting views between the local representatives and the national policymakers. It may be that the national representatives are not aware of the pace of change, or that they are keen to ground ANPs firmly within the nursing domain, contrary to what the experiences of the ANPs in this study shows. This has implications for the acceptance and adoption of a national framework and any future regulations of advanced roles. As one participant described: *“By the time any policy is in place, the landscape and practices will have moved on”* (GP participant). The ANP workforce may be evolving at such a pace, transitioning to a third-space between the nursing and medical professions, that the national leadership are ‘playing catch-up’, trying to remain relevant, and any attempt to regulate and standardise the role is ultimately dismissed because it is forever out of date and doesn’t allow for fluidity and innovative changes.

## 6.4 The paradox of advanced practice

The ANPs in this study were aware of their background as nurses but were frequently referred to and mistaken for doctors. This reflects their medicalised practice, widening scope, contrasting demeanour to that of practice nurses, and their undertaking of increasing numbers of previous GP-only tasks. Previous studies have suggested that patients prefer to consult with ANPs due to their style and individualised care (Jakimowicz et al., 2015). This study did not explore patients' views, but its findings suggest there may be challenges to such views of ANPS as they reduce their appointment durations, deal with increased complexity, refer to general nurses to carry out traditional nursing tasks, and become routinely mistaken for GPs by patients.

The nurses in this study, when pushed on their professional identity, wanted to remain largely in the nursing sphere yet were aware they were working as something else, in a hybrid role. Their nursing heritage and their advanced practice education equipped them for the day-to-day practices, but they needed to adopt a medicalised demeanour, strategy, and way of working to meet increasing patient demand and broaden their scope. This presented them with a paradox: align with the medical profession more closely or remain as nurses. They appeared to be, consciously or not, transitioning to a medical model. They also did not want to be associated with general nurses who were dealing with minor illness conditions without the formal ANP qualification, a distinction that further separates them from the general nurse. Their role as an ANP also meant they were socialising, training and attending update events with GPs rather than nurses and identifying themselves as part of the medical workforce rather than the nursing workforce. This was a choice on their part as the medicalised training events and meetings were more appropriate for their role, further distinguishing them from their general nurse colleagues.

The ANP participants recognised this duality, having a nursing background but working in a medicalised role. None of the ANPs appeared to regret having insufficient time to develop close nurse–patient relationships to provide more holistic management, as in the traditional nursing role. They valued diagnosis, the curing of ailments, prescribing, targets, appointment demands, and investigations and results over the traditional nursing qualities of communication, holistic care, caring and relationship building. McGiven et al. (2015) writes that when nurses undertake advanced roles, there are challenges to the nurse–patient relationship. This present study goes further in suggesting the nurse-patient relationship may be replaced by something else as the transitional aspect of their move towards a medicalised model, the ANPs personal

experiences during this transition, and their abandonment of traditional nursing roles may have an as yet unexplored influence on their role with patients. McGiven et al. (2015) asserts that the traditional caring, nurturing and holistic practices of nurses are challenged when undertaking advanced roles, as they struggled to maintain these skills, with the authors being concerned that they are being eroded. This present study stands in contrast to this, demonstrating that ANPs were aware of these changes and were embracing them, adopting a more medical model, and delegating traditional aspects of nursing to their colleagues. The ANP participants were working largely in a GP capacity, mistaken for doctors, with their strategising and thinking being medicalised in nature, yet they wanted to presently be known as nurses, concerned about how far the transition will take them, and fearful of a generalised ACP workforce, thereby creating a paradox.

Their desire to be recognised as nurses was also evident in their responses towards the ACP role and the framework for advanced practice. They were concerned that multiple professions in advanced roles all being referred to as ACPs could generalise the workforce and create a new medicalised identity without a clear, identifiable background profession. Paradoxically, this was the same process of change the ANPs were going through; moving towards a medicalised role and being mistaken for doctors, a change they were aware of and actively participating in. The difference in the latter is that ANPs were in control, adapting and innovating according to local pressures, rather than having to conform to a one-size-fits-all approach devised elsewhere.

The paradox created by the evolving ANP role, nurses simultaneously wanting to remain as nurses but pursuing a transition to a medicalised role, was not recognised by the national leadership. They wanted to emphasise the unique ability of nurses with their communication and caring skills, describing the HEE Framework (2017) as an embrace of all the differing professions and their individual abilities. It may be that it is ultimately rejected or ignored as ANPs may have transitioned away from the framework's parameters. The individualistic nature of ANP practice is also missing from responses of the national representatives. A standard model and regulation of all advanced practice would not align with the findings of this study, where ANPs were adapting their individual roles to suit the needs of individual organisations and their patient populations. It may also be the case that the national HEE Framework (2017) is used for initial ACP education only, allowing for further adaption and evolution of the role once qualified. It has been suggested that this amalgamated training between all professions may have negative implications for professional individuality and identity thereby limiting the role's effectiveness (Hoeve, 2014). This study suggests that at local

level there may be other, as yet unanticipated consequences, as professionals with advanced qualifications adapt themselves to local conditions and take advanced practice in new directions.

In addition, national HEE and NHS representatives indicated that the framework could possibly be used to introduce an online register and aid in further regulation of ACPs, and therefore ANPs. This was concerning to the local representatives and ANPs, demonstrating a disparity of views and a further paradox: the need for title protection and regulation, yet the desire to be free of restrictions in order to adapt and innovate.

### 6.4.1 To regulate or not to regulate

In addition to ANPs paradoxical approach to role recognition, they also displayed contrasting views on formal regulation and title protection. They were fiercely protective of their status, training and qualifications, dismissing as not being true ANPs any nurse who was undertaking a lesser role yet using an advanced title. They also expressed a clear desire to see title protection, NMC regulation and formal recognition of the role. In addition to this, they wanted the role to remain fluid, able to adapt to local pressures, and free from a centrally defined scope of practice that they saw would limit innovation. This duality was also seen in the local policymakers, who valued the role and did not want any national guide or framework to hinder their ability to utilise ANPs in local service provision, yet were keen to see more guidance on the scope of the role.

Previous studies by Currie and Crouch (2008), Keating et al. (2009) and Lloyd-Rees (2016) have highlighted advanced nurses' concerns that a lack of regulation and protections has hindered ANP progression. The present study stands in contrast to these as ANPs and commissioners expressed a desire for the role to remain adaptable with fluid boundaries above all else, as these were seen to be beneficial traits. Recent increases in patient demand and reducing GP numbers may have been a driving factor in ANPs acting as change agents, becoming more innovative, and may have led to commissioners using the role more creatively. In turn, national regulation and a clear scope of practice become undesirable as they were viewed as restrictive. This has implications for the national debate and policymaking, with the leadership pushing forward with the ACP framework and a standard education system, seemingly against the desires of the local workforce.

It now appears that any formal regulation of ANPs would be done in conjunction with ACP regulation. There remain many questions around titles, scope, boundaries and

practices and these are not currently addressed in any national framework or policy. This leads to confusion, but also aids the transition of ANPs to a hybrid third space without formal restrictions. How each profession views the world, healthcare and advanced practice is an important consideration. Professional identity is developed before individuals enter the profession, and then enhanced when they are training (Denzin and Lincoln, 2000). Nurses, doctors and allied professionals have a strong professional identity when they qualify, which influences how they practice (op cit., 2000). They are educated separately, embracing their unique abilities and traits. Nursing generally comes from a humanistic interpretation of the world (Denzin and Lincoln, 2000), whereas a paramedic is arguably more aligned to a biomedical (realist) perspective. The education of a generic advanced practitioner has to take into account these differing approaches and contrasting interpretations of knowledge. The regulation and identity of the role also has to take these factors into account. The possible joint regulation and strategy of all advanced professions under one umbrella, as described by the national policymakers in this study, risks alienating the workforce as they question their identity and boundaries, thereby reducing effectiveness and outcomes (Hoeve, 2014).

In addition to the educational standardisation of advanced roles, a ‘one size fits all’ approach to advanced practitioner practice was found to be the method of choice for the national leadership participants. The HEE framework was referred to as a device to standardise and generalise the role and introduce a ‘level playing field’. It may be the case that the HEE Framework (2017) has the effect of lifting unqualified nurses working as ANPs up to the desired level, although there is no evidence in this study or in the literature that this would be the case. There is, however, widespread concern that it would have the opposite effect of lowering ANPs to a more generalist role.

Governance and regulation are important areas for consideration however, as ANPs evolve and nursing in general advances. Maier (2015) described governance as the structures and processes through which policies are enacted to achieve goals, including legislation, regulation and oversight. National regulation occurs by statute or government decree and involves national-level registration, protection of professional titles and definition of the scope of practice (Carney, 2016). This recognition of the role, level of practice, and scope legitimises the profession, provides clarity for the public and other professionals, and sets clear standards for the protection of public safety (Heale and Buckley, 2015). Despite this, the UK has no formal regulation or protection of the ANP role beyond initial qualified nursing registration. The titles, responsibilities and scope are delegated to CCGs, managers and employers to decide. This has led to a

piecemeal development of the role, but has also aided innovation and adaptability, as seen in this study. Moffat, Martin and Timmons (2014) suggested that the negative consequence of a decentralised regulatory and governance system is the 'responsibilisation' of ANPs and their self-governance, which in turn leads to variability and ANPs being responsible for their own scope of practice. This study builds on and contrasts this previous research by uniquely showing that this self-governance, argued against by previous researchers, may have actually aided innovation and broadening of the ANP scope of practice, as ANPs and their GP employers increasingly adapt the role to suit local pressures and requirements.

The HEE framework and RCN credentialing scheme are not the only voluntary strategies in existence, with Health Education Yorkshire and the Humber (HEYH 2015), West Midlands (HEE 2015) and East Midlands (Health Education East Midlands 2015) all developing their own. The participants in this study expressed confusion regarding the multitude of frameworks, strategies, and guides, unsure which is correct and how they are to be implemented. Over the five years since these publications, ANPs, GPs, commissioners and managers have continued to forge their own path, using the unique skills that advanced nurses have developed and are developing, and improved patient care and access, all without a national cohesive strategy or central policy.

Perhaps the central argument for the regulation of advanced roles is to enhance patient safety. Nurses undertaking autonomous medicalised roles, diagnosing, prescribing and managing complex conditions should be qualified appropriately. As previously discussed, there is a lack of UK regulation around titles and scope of practice. This contrasts with other developed countries where there are clear boundaries, scope of practice guides and regulations (Cooper et al., 2019). Despite more formal regulations within countries such as the United States of America, Australia, and Canada, there are still considerable issues within these countries around definitions, protections and titles (King, 2017). In the UK the lack of regulation and protections has led to general nurses undertaking minor illness clinics within general practice and being referred to as 'advanced nurses' (King & Tod, 2017). This blurs the line between nurses and ANPs and leads to the resentment from ANPs towards 'minor illness nurses' who they see as unqualified. The definition of a minor illness is also vague and separating the patients with serious disease from those with minor illnesses requires skill and expertise, skills which the ANPs viewed as being within the ANP and GP domain.

Regardless of these concerns, many practice nurses undertake minor illness clinics with little extra training or qualifications. This is a very different role from the fully qualified

ANP who is shown in this study to be transitioning to a more GP-like status, but nevertheless leads to confusion. Requiring that every GP and ANP see all patients with a minor skin ailment, sore throat, or strained muscle is an inefficient use of resources. With increased demand and a reduction in GP numbers, minor illness clinics are an attractive proposition and nurses are stepping up to fill this gap, unregulated and in a piecemeal approach. The effect of general nurses managing minor illness is ANPs and GPs dealing with more complex patients and becoming more aligned in their practices, marking a distinction between ANPs and practice nurses. This may also be driving the ANP to transition to a more medicalised model of practice towards a new, hybrid role.

## 6.5 Summary

This chapter has discussed the findings of the study in depth, in relation to the relevant literature and themes that emerged from the data. The multifaceted issues around identity have been discussed, along with their relevance to the published literature. ANPs were aware their identity was evolving and transitioning to a hybrid third space between the two professions, but still considered themselves nurses, thereby creating paradoxes with their identity, scope of practice, and role boundaries. The contradiction is that defining roles and titles will define territory. Any definition of the role, scope and boundary risks hindering the ANPs' ability to innovate, adapt and move into new areas of practice. All the ANP participants displayed a sense of loyalty to their organisations, personal pride, satisfaction with their work, and eagerness to progress further; all these are factors influencing their self-identity. The national healthcare and nursing leadership were less aware of the issues around identity and the ANPs' transition to a possible hybrid role. This creates a disparity of views and has implications for national strategy going forward regarding protections, titles, the implementation of a national framework and future regulations.

The ANP participants did not see themselves as formal substitutes for GPs, although viewed themselves as undertaking largely the same role, moving into a medicalised domain of practice. This contradiction has implications for role recognition and acceptance by other health professionals and the public. Commissioners and managers were keen to utilise the role in all aspects of service delivery, seemingly with their ANPs' enthusiastic support, further broadening their scope of practice. Views were disparate between the local representatives and the national leadership on the ANP role's utility and adaptability, demonstrating a disconnect between the two groups which has implications for policy.

What is clear is that nurses in advanced roles feel they are effective, a feeling supported by their being used in increasing numbers to fill gaps in service provision. ANPs are eager and willing to undertake these roles, often retraining to adopt medicalised duties and tasks. This is transitioning them to a hybrid-type role, blurring the boundaries of nursing and medical professions and causing ANPs to question their identity. The national strategy appears to be one of standardising the education and practice of ANPs and allied professionals using a national framework, irrespective of their background. There are concerns that ACPs in training are encouraged to largely dismiss their professional background in favour of a generic medicalised role. This risks the advanced practitioner abandoning the unique skills and experience gained in their individual profession and has further implications for their self-identity and future effectiveness.

The nursing leadership were keen to stress the traditional attributes of the nurse – caring, compassionate, good at communication, with empathetic skills, and how these can influence advanced practice. There was a failure to recognise that the ANP role was bridging the boundaries of the nursing and medical domains and transitioning to a new status. This transition was due to the individual tenacity, innovative desire, and adaptability of the ANPs, traits that risk being lost with a one-size-fits-all strategy. The findings of this study suggest that ANPs are using their basic nursing education as a foundation, abandoning many of their traditional nursing skills and duties in favour of adopting a more medicalised role. They are increasing their knowledge and scope of practice, transitioning to a new area of practice outside the usual nursing sphere, all of which risks being overlooked by the national leadership and policymakers in favour of a standardised, multidisciplinary model.

## 6.4 Limitations

In line with qualitative grounded theory methodology, this study was not intended to test a hypothesis, prove a theory or draw any firm inferences. However, the study's methodology has provided useful insights that could inform national healthcare policies and development of the advanced practitioner role, and aid workforce planning in primary care. Research is scarce around the ANP role within general practice and its recent evolution. Even fewer studies have compared the views of the workforce with their leaders, commissioners and managers, so this study demonstrates a clear addition to knowledge.

This study was based in the north of England and may not reflect the views and experiences of all ANPs in differing areas of the country, undertaking a variety of roles. The national representatives cannot feasibly be aware of all the issues in every area around advanced practice, so specific ANP issues in this study may not reflect the national picture. The small sample size of each group of participants cannot reflect the whole workforce and be generalisable in a quantitative sense, nor was it intended to. The themes, patterns of behaviours, responses and experiences of the participants, however, may resonate with other ANPs, commissioners, managers, GPs and NHS leaders and lead to a wider debate around the general practice ANP role.

All the phase one participants were female, referred to themselves as nurses and were experienced in their roles. This sample may not reflect the thoughts and experiences of newly qualified ANPs or indeed ACPs undertaking their new roles. The findings around identity and self-perception may influence further studies on the introduction of the ACP role and how this impacts existing ANPs. While this study focused on ANPs, the identity, scope and experiences of physiotherapists, pharmacists and paramedics moving into general practice ACP roles may be influenced by this research and studied in light of its findings, as each has its own identity and professional background, while working under the joint ACP domain.

The focus of this study was on general practice. ANPs working in other areas of both primary and secondary care may be experiencing different pressures, encouraging different identities, roles and practices. The independent contractor status of GP surgeries may lend itself to a dynamic and fluid workforce, able to adapt and implement changes more rapidly than a larger organisation with multiple layers of supervision and management. The unique pressures placed upon general practice may be shaping the ANP role in different ways to advanced nurses working in very different environments such as an acute hospital setting. These areas may possibly experience more restrictions on their adaptability, boundaries, and scope, and is an area that warrants further study.

# Chapter 7

# Conclusion and Recommendations

## 7.1 Conclusion

The aim of this research was to explore, compare and contrast the views of ANPs, managers, NHS leaders, commissioners and employers with respect to the current and evolving role of the ANP in general practice; to develop a new understanding of current ANP practice; and to make policy and workforce recommendations. The unique findings that emerged from this study suggest that ANPs are finding themselves at the forefront of service delivery, taking on more tasks previously seen as doctor-only, and broadening their scope to accommodate increased demands from patients and a reduction in GP numbers. As a result, they are aware that their role is becoming increasingly medicalised and transitioning to what this study has referred to as a new third-space position, perhaps occupying a hybrid role between the nursing and medical professions. They considered themselves nurses but were aware that they were something *other* than a general registered nurse; accepting of this role, they were willing to take on the challenges that the current climate presents them with. In contrast, the national leadership appeared to lack awareness of this transition and were keen to promote the roles as purely nursing, although one that has now found itself within the ACP arena, alongside allied professionals.

There were contradictions in the thinking and responses from ANPs regarding regulations and protections. They were keen to express frustration with nurses who used the ANP title and who had not undergone the necessary training but were sceptical and concerned that any framework and mandatory regulation of the role would restrict their innovative nature and hinder their progress. In contrast, the national workforce representatives and NHS leaders saw the HEE framework as a solution to the issues of variability and role confusion. The ACP role and framework appeared to present ANPs, GPs and commissioners with further confusion around advanced roles, scope of practice and the implementation of these within general practice.

ANPs were found to be very enthusiastic, innovative and willing. Their employers, local commissioners, GP participants and managers were complimentary regarding the role and its ability to adapt. This study represents a new contribution to knowledge around the evolving nature of the role, the contradictions and disparity of views among the local

workforce and national leadership, and concerns for the identity of the role in the future. ANPs are now found in all areas of healthcare, and nursing in general is becoming more advanced, experiencing widespread task-shifting from doctors to nurses (Nadaf, 2018). This appears to be happening organically as a result of local demands, changes to workforce dynamics, financial pressures and a move to be ever more efficient. ANPs were relishing the opportunity to expand their roles and undertake many medicalised tasks, previously regarded as doctor-only, and carrying them out, it seemed, with efficiency and dedication. By doing so, they were positioning themselves as increasingly separate from the traditional nursing model, and found themselves transitioning to a third-space, hybrid role between the nursing and medical professions. As these changes occur rapidly and organically, there is a risk that the national leadership, policymakers, and strategists will be continually trying to catch up.

## 7.2 Recommendations

This study has highlighted several key themes around ANP practice that remain contentious or unresolved. Below are recommendations for further research and policy development. These are based around strategy, education and future development of the ANP.

- A vision for the future of advanced practice is required. One that encompasses all professions and recognises their unique contributions. This would need to recognise that advanced practitioners occupy the middle ground between their individual professions and medicine. This appears to be recognised by the workforce but may not be by the leadership and strategists. The continual evolution of ANPs and ACPs means that a strategy and regulation may be difficult, but the lack of a cohesive strategy leads to questions around identity, scope, and boundaries.

- Recognition is needed among local and national leaders of the importance of ANPs and other advanced roles and their contributions to healthcare. There is a continuing presumption that they are subservient to the medical profession, evident in the national literature and policy, none more so than in the 2019 GP Contract, which saw nurses and ANPs barely mentioned. This contradicts developments at local level. A national drive and campaign to recognise

advanced roles would go a long way to promoting them as stand-alone practitioners, not simply gap-fillers and mini-doctors.

- Further research is needed in other areas of the country that may not be experiencing a shortage of GPs as significant as the areas in this study. GP surgeries located in large cities may not be experiencing the workforce challenges that were found in the surgeries located in small northern towns included in this study.

- The HEE framework (2017) and the RCN credentialing scheme do not appear to be relevant to the ANP participants in this study. In addition to this, they do not address the problem of unqualified nurses and allied professions working as ANPs and ACPs. The regulation of the role currently remains with local managers and employers which results in variability. If the HEE framework is to form the basis of more substantial regulation of advanced roles in the future, this study has shown contrasting views amongst the national leadership and policy makers on how this can be achieved, and demonstrates concerns from the ANPs and local commissions, who were fearful of any restrictions on the role. These contrasting views and experiences require resolution before a joint strategy can be adopted.

- Further research is required on the implementation of ACP roles and their impact on outcomes, demand, access, and existing staff. If ACP roles are to be modelled on the ANP role, to avoid the lack of understanding demonstrated amongst the GPs, commissioners and managers on the role and its implementation within existing practices, more effective communication and detailed information is required between the ground-level workforce, the local requirements, and the national policymakers.

This research aimed to use a grounded theory methodology to explore the evolving role of the ANP within UK general practice by analysing the views of the ANP workforce, their experiences and drivers, and compare and contrast these with the views of the local and national leadership and key stakeholders. The aim was to assess the current state of ANP practice, develop a new understanding of the role, determine if the current systems of developing and supporting ANPs are fit for purpose, and make policy

recommendations based on the findings. Achieving this aim required gaining a clear insight into current ANP practice from the lived experiences of ANPs and comparing these findings with the phase two participants were clear objectives in this research.

The study shows that ANPs are adapting and innovating organically, advancing their roles, developing new working practices, and forging new areas of advanced nursing practice. As a result, they are questioning their identity and boundaries and ultimately moving to a new third space between the nursing and medical professions. This has implications for the nurse/doctor relationship and the boundaries between the professions. If the ANP moves further into the medical domain, and allied professions also enter the advanced practitioner arena, as this study suggests may happen, the traditional hierarchical structure and role seniority of the GP towards the practice nurse and other professions within general practice will continue to evolve, and may result in the GP not being the central and first-line figure within general practice. It may perhaps also be the case that the future makeup of general practice is one of advanced practitioners, without a clear background profession, using the ACP “title”. This has implications for national nursing leadership bodies. This study shows confusion amongst the workforce and disagreement within the national leadership representatives about the direction of change within ANP professional identity. The national bodies do not recognise the changes in nurses’ personal identity, domain, their relationship with the medical professions, and their scope of practice. While the nurses in this study are taking on a new and different identity, more related to medicine, they also want to be nurses. The results have shown a disparity between the local and national participants around role recognition, where the ANP role sits within the professions and how governance and regulation should develop. This disparity may indicate a lack of understanding amongst the national leadership on how the role is evolving and transitioning to a medical model, away from the traditional nursing domain, thereby creating a new professional identity.

There are implications also for the medical profession. The additional roles entering general practice and the continuing rise and evolution of the ANP marks a change in the protectionist nature of the medical establishment. The willing enablement of the ANP, the task shifting from GPs to ANPs, and the GP contract actively encouraging this task shifting via the introduction of allied advanced roles, may be a sign of the GP workforce recognising the need to adapt, a sign of desperation because of the lack of GPs, or the natural division of labour arising from the ongoing cost-effectiveness drive to provide effective healthcare at the lowest cost.

In conclusion, this study suggests that what it is to be a nurse, a doctor, an advanced clinician and a professional is changing, and this poses questions worthy of further study, especially around the concepts of role boundaries, scope of practice, the domain of influence, and how these phenomena relate to the professional identity of those involved in the changes; GPs, nurses, ANPs, pharmacists, paramedics and physiotherapists. Any further regulation, governance and protections for advanced roles, and the effective introduction of these additional roles to general practice, may require that these issues be addressed.

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**Appendix 1 – Participant information sheet**

Version 4 1/3/19
IRAS ID: 254502

## Participants Information Sheet

**Study Title: The evolving role of the advanced nurse practitioner within general practice. A qualitative study on the views of NHS leaders, commissioners, managers, GPs, and advanced nurse practitioners.**

**Part 1** tells you the purpose of this study and what will happen to you if you take part.

**Part 2** gives you more detailed information about the conduct of the study.

### Part 1

We would like to invite you to take part in a study on the evolving role of the advanced nurse practitioner (ANP) within general practice. The process involves audiotaping a semi-structured interview with the health care professional or NHS manager/leader and will last approximately 1 hour.

Before you decide whether to participate, you need to understand why the research is being done and what it would involve. Please take time to read the following information carefully and talk to others about the study if you wish.

Please ask if there is any other information you require before taking part: lee.hough@wakefieldccg.nhs.uk

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### 1. What is the purpose of the study?

This study aims to highlight any possible disparities between what commissioners and managers view as being the future for the role, and what

ANPs themselves see as safe, competent and effective practice for their level of training and support.
Areas of enquiry will include the training ANPs have previously undertaken to enable them to carry out their current role (there is a national variability in levels of ANP training), levels of support, governance, pressures to undertake new roles, and the future requirements of the role to meet increases in healthcare demand.

## 2. Why have I been invited?

You have been invited as you are a practicing ANP within general practice, undertaking an advanced role in an area of change and innovation, or you are a NHS leader/commissioner or manager responsible for workforce development or ANP strategy.

## 3. Do I have to take part?

Your participation is entirely voluntary, and it is up to you to decide whether to take part. Further information will be provided at the interview and the interviewer will go through this sheet before it begins. You will be asked to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason either before, during or after the interview. If you withdraw after the interview, your information and data will also be withdrawn.

## 4. What type of study is this?

This is known as a qualitative study that uses the method of face-to-face interviews. The experiences of ANPs currently working in general practice, meeting patient demand, with fewer staff and resources may have innovative or detrimental effects of the ANP and his/her role. To find out, we need to interview ANPs to gain their insights into the role and how it is adapting to the current NHS and primary care climate. By recording and analysing the conversations, we are able to obtain useful information which will be used for analysis. We are also interviewing NHS leaders/commissioners and managers around their understanding of the ANP role and its evolution.

## 5. What will happen to me if I take part?

If you agree to participate, you will be asked to sign a consent form. The interview will take place at a mutually agreed time and place, usually at your convenience. This will not affect your current role. Please see below regarding confidentiality and anonymity.

## 6. What will I have to do?

You are required to answer the questions based on your personal experience during the interview. However, you can refuse to answer any questions which you feel uncomfortable and you can stop the interview at any time.

## 7. What are the possible disadvantages and risks of taking part?

The semi-structured interview is relaxed and based around the ANP within general practice. The researcher is bound by NMC code of conduct rules and regulations. All responses are treated as confidential (as stated in the consent form) and data is stored securely and anonymously. When the results are analysed, no names, places, dates or identifying information is included. Your employer will not be aware of your individual responses to the questions.

## 8. What happens when the research study stops?

The results will be made available to all participants and published. No identifying information will be included.

## 9. What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be investigated. The detailed information on this is given in Part 2.

## 10. Will my taking part in the study be kept confidential?

The researcher will follow ethical and legal practice and all information will be handled securely and anonymously. No identifying details are included in the study. The details are included in Part 2.

## 11. Is the purpose of this study educational?

Yes. The data collected will be used as part of a doctorate with the University of Bath, supported by the Queens Nursing Institute.

**This completes Part 1.**

**If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.**

**Part 2**

## 12. What will happen if I don't want to carry on with the study?

You can withdraw from the study without giving a reason at any time and without affecting your current role.

## 13. What if I need to contact you at any point?

If you have a concern, would like to ask a question or wish to rearrange an interview date, please contact the researcher at:
Lee.hough@wakefieldccg.nhs.uk

## 14. Will my taking part in this study be kept anonymous?

The recorded conversation will be transcribed by a designated NHS secretary. Only the interviewer and the secretary will have access to the audio. All information will be coded and anonymised. Only the researcher will have access to information which can identify you and the secretary will not be aware of your name or place of work. Once the transcript has been completed and checked by the interviewer for accuracy, the audiotape will be erased by the secretary in the presence of the interviewer.

The information we have collected as paper copies will be stored under lock and key, while the electronic data can only be accessed with a secure password. Only the researcher has access to this data. No secondary party has access.

The University of Bath is the sponsor for this study based in the UK. We will be using information from you provide in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Bath University will keep identifiable information about you for 10 years after the completion of the study in line with their research policy.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information:
lah63@bath.ac.uk

The researcher will use your name and contact details to contact you about the research study, and make sure that relevant information about the study is recorded to oversee the quality of the study. Individuals from the University of Bath and regulatory organisations may look at your research records to check the accuracy of the research study. The researcher will pass these details to the University of Bath along with the information collected from you. The only people in the University of Bath who will have

access to information that identifies you will be people who need to contact you to undertake the research or audit the data collection process. The people who review the information will not be able to identify you and will not be able to find out your name or contact details.

The University of Bath will keep identifiable information about you from this study for 10 years after the study has finished.

## 15. Involvement of your manager/employer.

You may wish to inform your employer or manager of your involvement in the study, but this is optional. No information gathered from the interview will be fed back to your manager, employer or governing body.

## 16. What will happen to the results of the research study?

The results of this study will be published in journals. A summary of the results will be sent to you by post or email if you request this.

You will not be identified in any report, publications or presentation. Direct quotes from the interviews may be used in reports and publications; however, the quotes will be anonymised to ensure that you cannot be identified.

## 17. Who is organising and funding the research?

The study is part of a doctorate with the University of Bath. White Rose GP Surgery, Health Education England and The Queens Nursing Institute has provided an amount of funding.

## 18. Who has reviewed the study?

All research in the NHS is verified at by an independent group of people, called the Health Research Authority (HRA) to protect your safety, rights, well-being and dignity. This study has been reviewed by the University of Bath Research Ethics Approval Committee for Health (REACH).

## 19. Further information and contact details.

University of Bath: www.Bath.ac.uk

NHS Research ethics: https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/

Queens Nursing Institute: https://www.qni.org.uk/

Specific information about this research projects data protection policy:
Prof Jonathan Knight

Email: pro-vc-research@bath.ac.uk
The researcher has had an enhanced DBS check in 2016, is NMC registered, bound by the NMC code of conduct and is an NHS employee.

## Appendix 2 – Participant consent form

Participant Number/Initials:

Version 4 1/3/19
IRAS ID: 254502
**Title: The evolving role of the advanced nurse practitioner within general practice. A qualitative study on the views of NHS leaders, commissioners, managers, GPs, and advanced nurse practitioners.**

**Consent Form for Interview**

Thank you for reading the information sheet about the study.
If you are happy to participate then please complete and sign the form below.
Please initial the boxes below to confirm that you agree with each statement:

I confirm that I have read and understood the information sheet dated **[15 Feb 19]** and have had the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. ☐

I understand that my responses will be treated as confidential and stored anonymously. I understand that my name and or position will not be linked with the research materials and will not be identified or identifiable in the report or reports that result from the research. ☐

The researcher is bound by the NMC code of conduct and any potential breaches of this code have to be reported in line with regulatory requirements ☐

I agree for this interview to be tape-recorded. I understand that the audio recording made of this interview will be used only for analysis and that print only extracts from the interview, from which I would not be personally identified, may be used in any conference presentation, report or journal article developed as a result of the research. I understand that no other use will be made of the recording without my written permission, and that no one outside the researcher will be allowed access to the original recording. The original recording will be erased following analysis. ☐

I agree that my anonymised data will be kept for future research purposes such as publications related to this study after the completion of the study. ☐

I agree to take part in this interview. ☐

| | | |
|---|---|---|
| _____ | _____ | _____ |
| **Name of participant** | **Date** | **Signature** |
| _____ | _____ | _____ |
| **Principal Investigator** | **Date** | **Signature** |

**Copies**: *Once this has been signed by all parties the participant will receive a copy of the signed and dated participant consent form, and the information sheet. A copy of the signed and dated consent form will be placed in the main project file which must be kept in a secure location. The researcher has had an enhanced DBS check in 2016 and is NMC registered and bound by the NMC code of conduct.*

## Appendix 3 – Initial ANP interview guide/prompts

Tell me about yourself and your role, how did you get into advanced nursing

How you became an ANP, background
- Did you always expect to be an ANP
- Is your role what you expected

Training
- Ongoing
- Future needs

Does you training fit with what you do now
- Technical aspects
- Types of conditions

Future training requirements
- More training needs
- Adaptable and willing

Has your role changed, what's driving it
- Demand
- Patients
- GP numbers

How is it changing
- More medical model
- Still nursing

New duties and why
- Why taking on more duties if this is the case
- What timescales

Pressures
- Demand
- Patients

Stress
- From what
- Support from colleagues, GPs, education, clinical

More advanced roles/duties and why
- Types
- Descriptions
- Examples

How might the role adapt in the future
- Further reduction in GPs
- Other advanced practitioners, PA

Salary reflecting duties
- Management responses

GP numbers
- Changes, reductions, part time
- Do GPs recognise the ANP role effectively

Patient preference and response to the role
- Patient responses
- Do they see a difference

Differences between ANP and GP
- Main ones, any differences

Technical changes, more medical, nursing "caring role" or now medical

Nursing leadership, NHSE, RCN, NMC, CCG, are they aware of the ANP role and changes, support, education

Views of ANP from GPs, Commissioners, leadership, colleague

## Appendix 4 – Example of a memo

March 6th, 2019

ANP interview – mid size surgery. 3 ANPs & 4 GPs

2 GPs recently retired and the ANPs taking on end of life care and diabetes – doing more training

ANPs seem happy to do it – no pressure. Wages reviewed once they've done the course and started the role

1 ANP does most of the daily home visits

Interview – some issues around titles. Practice nurse does some minor illness - calls herself practice nurse. A couple of the GPs sometimes refer to her as ANP which gets on the ANPs nerves as she's not qualified. ANPs has aspirations for the future and would like to do palliative care degree and specialise – she's not sure if there's a role for it though. ANP specialising is becoming more common. No communication between surgeries and between ANPs in different surgeries to share practices – working in isolation. Says they're largely left to determine their own role as the GPs don't understand the scope or what's involved. A common finding and need to explore this with phase 2 and with GPs around leaving the ANP role for ANPs to decide.

Does self-determination of role affect morale or identity?

Does the adaptability of these ANPs increase outcomes and improve care?

## Appendix 5 – University of Bath research ethics approval

Faculty of
Humanities &
Social Sciences

UNIVERSITY OF BATH

Bath BA2 7AY · United Kingdom

Mr Lee Hough
Department for Health
University of Bath
Bath BA2 7AY
England

22 January 2019

Dear Lee

**Full title of study**: The evolving role of the advanced nurse practitioner within UK general practice. A qualitative study on the views of employers, commissioners, GPs, nursing and NHS leaders, and advanced nurses.
**REACH reference number**: EP 17/18 254

On behalf of the Committee, I am pleased to confirm that the Committee would be happy to provide a favourable ethical opinion of the above research on the basis described in the application form and supporting documentation.

If you intend to display recruitment posters/materials, please ensure you obtain the appropriate permission to do so from those who manage the location(s) you choose.

Please inform REACH about any substantial amendments made to the study if they have ethical implications.

Please make sure you quote your unique REACH code, EP 17/18 254, in any future correspondence.

Kind regards

Rebecca

## Appendix 6 – University of Bath sponsorship approval

**Professor Jonathan Knight BSc, MSc, PhD**
*Pro-Vice-Chancellor Research*

**Vice-Chancellor's Office**
Bath BA2 7AY
Tel: 01225 386141
Email: Pro-vc-research@bath.ac.uk

6 February 2019

Lee Hough
Department of Health

Dear Lee

**The evolving role of the advanced nurse practitioner within UK general practice. A qualitative study on the views of employers, commissioners, GPs, nursing and NHS leaders and advanced nurses**

I am pleased to confirm that the University is prepared to act as a sponsor under the Department of Health's Research Governance for Health and Social Care (2005) subject to the following:

1. The University requires you, as the Principal Investigator, to conduct the study in compliance with the requirements of the Framework so it is able to meet its obligations as sponsor. The requirements are:
    - Developing proposals that are scientifically sound and ethical.
    - Submitting the design for independent expert review.
    - Submitting the study (or proposal) for independent ethical review.
    - Conducting a study to the agreed protocol (or proposal), in accordance with legal requirements, guidance and accepted standards of good practice.
    - Preparing and providing information for participants.
    - Ensuring participants' welfare while in the study.
    - Arranging to make findings and data accessible following expert review.
    - Feeding back results of research to participants.
2. University professional indemnity and insurance will apply to the study as appropriate, within the UK.
3. As the Principal Investigator/Chief Investigator for the study, the University requires you to comply with the University policy on research data and all systems of good practice.
4. Amendments to the study and any reports must be submitted to the sponsor.
5. An end of study report must be submitted to the sponsor using the final report form available here: https://www.bath.ac.uk/publications/forms-for-applying-for-university-sponsorship-to-work-in-the-nhs/
6. Any SAEs (serious adverse events) and any other incidents must be reported to the sponsor within 24 hours on the appropriate form available here: https://www.bath.ac.uk/publications/forms-for-applying-for-university-sponsorship-to-work-in-the-nhs/
7. Please note that this study could be subject to monitoring as part of our obligations as research sponsors. You will be informed separately if this is the case.

Yours sincerely

Professor Jonathan Knight
Pro-Vice-Chancellor, Research

## Appendix 7 – Health Research Authority approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mr Lee Hough
White Rose Surgery
Exchange street
South Elmsall
Pontefract
WF9 2RD

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

01 March 2019

Dear Mr Hough

**HRA and Health and Care Research Wales (HCRW) Approval Letter**

| | |
|---|---|
| **Study title:** | **The evolving role of the advanced nurse practitioner within UK general practice. A qualitative study on the views of employers, commissioners, GPs, nursing and NHS leaders, and advanced nurses.** |
| **IRAS project ID:** | **254502** |
| **Sponsor:** | **University of Bath** |

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

**How should I continue to work with participating NHS organisations in England and Wales?**
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum